Missouri State Board of Nursing Newsletter

The Official Publication of the Missouri State Board of Nursing with a quarterly circulation of approximately 119,000 to all RNs and LPNs

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Message from the President

Know Your Nursing Practice Act

Roxanne McDaniel, PhD, RN, President

Every nurse should know the Nursing Practice Act (NPA) and be aware of other laws and rules that govern nursing practice. The NPA is the most important legislation affecting nursing. It defines the scope of practice for specific nursing roles and gives nurses the legal authority to practice within their scope. Licensing laws were created to protect the public, ensure safe practice and to establish the rules and regulations for the specific level of a nurse's educational and licensure requirements

On August 28, 2013, the Missouri Nursing Practice Act was revised. See the changes below. Please note that the bold text indicates additions and the text contained in brackets shows deletions.

The Nursing Practice Act
335.066.

1. The board may refuse to issue or reinstate any certificate of registration or authority, permit or license required pursuant to chapter 335 for one or any combination of causes stated in subsection 2 of this section or the board may, as a condition to issuing or reinstating any such permit or license, require a person to submit himself or herself for identification, intervention, treatment, or rehabilitation by the impaired nurse program as provided in section 335.067. The board shall notify the applicant in writing of the reasons for the refusal and shall advise the applicant of his or her right to file a complaint with the administrative hearing commission as provided by chapter 621.
2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:

(1) Use or unlawful possession of any controlled substance, as defined in chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by sections 335.011 to 335.096;

(2) The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution pursuant to the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of any profession licensed or regulated pursuant to sections 335.011 to 335.096, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude, whether or not sentence is imposed;

(3) Use of fraud, deception, misrepresentation or bribery in securing any certificate of registration or authority, permit or license issued pursuant to sections 335.011 to 335.096 or in obtaining permission to take any examination given or required pursuant to sections 335.011 to 335.096;

(4) Obtaining or attempting to obtain any fee, charge, tuition or other compensation by fraud, deception or misrepresentation;

(5) Incompetency, [misconduct,] gross negligence, [fraud, misrepresentation or dishonesty] **or repeated negligence** in the performance of the functions or duties of any profession licensed or regulated by [sections 335.011 to 335.096] **chapter 335. For the purposes of this subdivision, "repeated negligence" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar**

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Executive Director's Report

Authored by Lori Scheidt, Executive Director

Licensed Practical Nurses Set to Renew in March 2014

Licensed Practical Nurse (LPN) renewal postcards with PIN numbers will be mailed to your address in early March 2014. They are mailed to the address on our records, so it is very important that you inform our office in writing whenever you change addresses. A change form can be found on the Board's website and also in this publication.

It takes 3-5 business days for your license renewal to be processed. You can go to www.nursys.com to check the status of your license at any time.

Legislative Session

The 2014 legislative session started January 8, 2014 and will go through May 16, 2014. Legislators began pre-filing bills on December 1, 2013.

Legislation impacts nursing careers, shapes health care policy and influences the care delivered to patients. Your education, expertise, and well-earned public respect as a nurse can allow you to exert considerable influence on health care policy. Nurses have been somewhat reluctant to do this in the past but you are in an excellent position to advocate for patients. Never underestimate the importance of what you have to say. As a professional, you bring a

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current resident or

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Princeton, MN
55371

Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of January 16, 2014

Profession	Number
Licensed Practical Nurse	25,508
Registered Professional Nurse	96,686
Total	**122,194**

http://pr.mo.gov

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Executive Director's Report continued from page 1

unique perspective to health care issues and often have intricate knowledge that helps provide insight for our legislators.

You should make your thoughts known to your legislative representatives. You can meet with, call, write or e-mail your legislators. Let your legislators know how to reach you, your area of expertise and that you are willing to give them information on issues related to nursing. You can find information about the status of bills and how to contact legislators at http://moga.mo.gov/.

Missouri State Board of Nursing Budget

Nursing regulation is the governmental oversight provided for nursing practice in each state. Nursing is regulated because it is one of the health professions that pose risk of harm to the public if practiced by someone who is unprepared or incompetent. The public may not have sufficient information and experience to identify an unqualified health care provider and is vulnerable to unsafe and incompetent practitioners. Through regulatory processes, the government permits only individuals who meet predetermined qualifications to practice nursing. The Board of Nursing is the authorized state entity with the legal authority to regulate nursing.

The Missouri State Board of Nursing approves individuals for licensure, approves educational programs for nurses, investigates complaints concerning licensees' compliance with the law, and determines and administers disciplinary actions in the event of proven violations of the Nursing Practice Act.

The renewal fee is $60 for Registered Nurses and $52 for Licensed Practical Nurses. $10 of the RN and $2 of the LPN fee is deposited in a fund with the Department of Health in order to administer the nursing student loan program. You can access more information about the nursing student loan program at http://health.mo.gov//living/families/primarycare/healthprofloans/index.php

The top three budget items for our office are professional services to investigate complaints, supplies and salaries. Supplies include postage. This year, we will mail approximately 25,000 renewal notices for a total postage bill of approximately $12,250. One of the ways costs can be decreased is to keep your address current with our office and renew online EARLY.

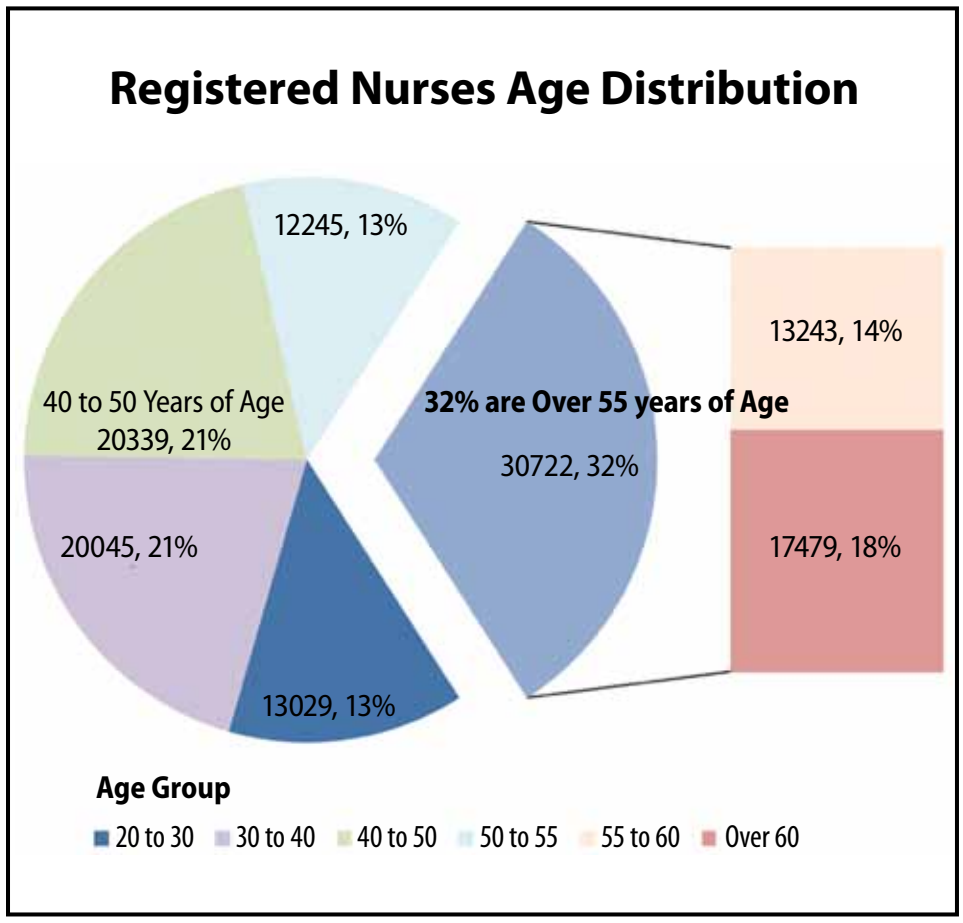
The Board of Nursing's fund is also assessed costs from the Division of Professional Registration, Department of Insurance, Financial Institutions and Professional Registration and Office of Administration. These costs include services such as computers, information technology support, purchasing staff, accounting staff, web site maintenance, and licensing renewal processing staff. In addition, our office utilizes the Office of the Attorney General for some of our legal counsel work.

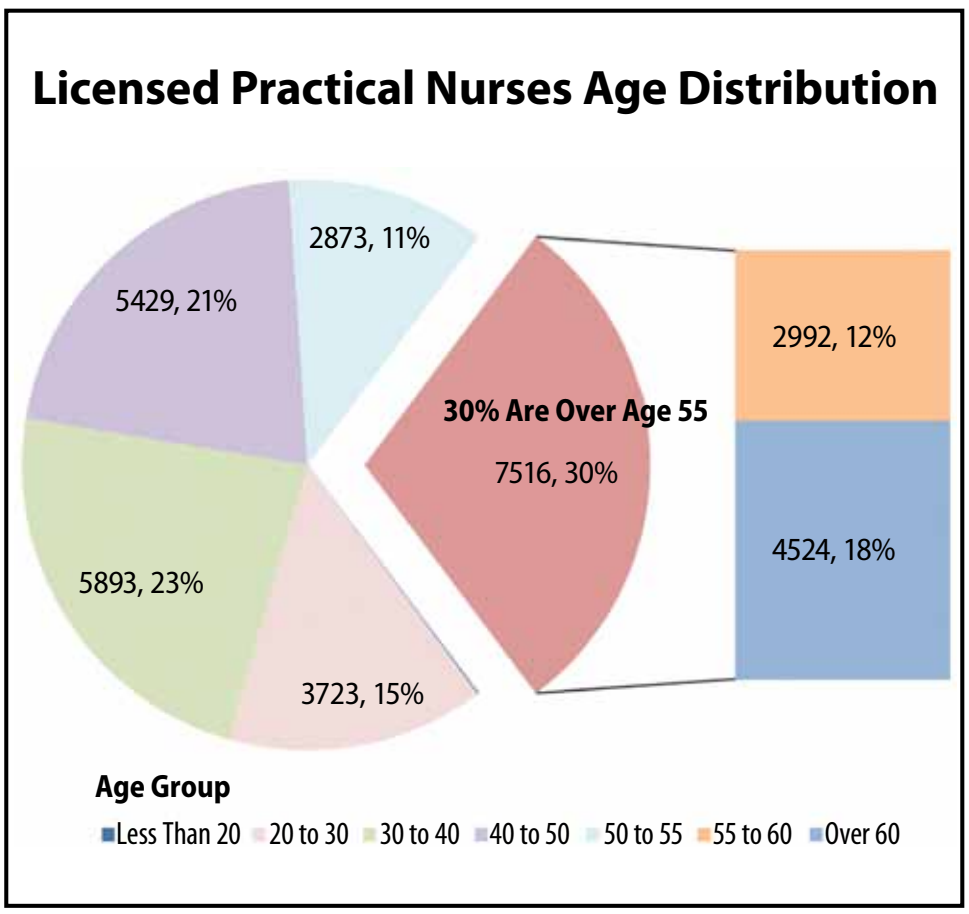
RNs renew every two years in odd-numbered years and LPNs renew every two years in even-numbered years. Since there are more RNs than LPNs, the Board receives more revenue in odd-numbered years than in even-numbered years. The RN renewal cycle is February to April. The LPN renewal cycle is March to May. When determining revenue and expenses, you have to plan to have enough reserve in the fund to pay expenses until the revenue from renewal fees is received. State statute 335.036.4, RSMo, indicates that the Board of Nursing funds cannot be placed to the credit of general revenue unless the amount in the fund at the end of the year exceeds two times our appropriation. This prevents the Board from charging excessive fees and also explains why renewal fees may fluctuate from year to year.

During the Board's quarterly face-to-face meetings, the Board diligently reviews financial statements. We are very cognizant of the fact that nurses pay for the operation of the Board and continually look for ways to cut costs.

Within the next two years the Board will be transitioning to a new licensure system. We expect to see a decrease in operational expenses and increase in customer satisfaction and efficiencies when this system is fully implemented.

It is likely that we will see a steep decline in our revenue. It is often difficult to predict how many nurses will not renew. Of concern is that 17,479 (18%) of RNs and 4,524 (18%) of LPNs are over age 60. Even more alarming is the fact that 30,722 (32%) of RNs and 7,516 (30%) of LPNs are over age 55. We know that nurses come back into or stay in the workforce when the economy is down. The numbers show many nurses are older and will retire in the near future, just when the wave of baby boomers hit retirement age themselves and need more nursing care. When this large population of older nurses retires, our revenue will steeply decline. The Board will continue to monitor this trend.





Education Report

Nursing Education - Responsibility, Trends, and Options

Authored by Bibi Schultz, RN MSN, CNE Education Administrator

Missouri State Board of Nursing (MSBN) Education Committee Members:

- Roxanne McDaniel, RN, PhD (Chair)
- Lisa Green, RN, PhD(c)
- Mariea Snell, MSN, BSN, RN, FNP-BC

As the profession of nursing evolves, the need for transformation of how nursing students are taught and learn is very real. Transition to practice plays a huge role in patient safety as well as efforts to retain new nurses in clinical settings. Dr. Christine Tanner (2010) calls for creation of a system for nursing education through strong partnership between community colleges and universities that provides for common pre-requisites, utilizes competency-based nursing curricula and actively shares instructional resources to maximize opportunities for students and faculty. Dr. Patricia Benner (2010) identifies three major areas of apprenticeship in nursing education. Those areas include acquisition and utilization of nursing knowledge, development of clinical reasoning skills and ethical decision making. Dr. Benner and colleagues indicate the need for increased focus on scientific principles and clinical learning in nursing education. The need for standardization of pre-requisite course work, use of more effective teaching strategies, and direct linkage of patho-physiology and disease concepts to actual and simulated patient responses is reiterated.

Dr. Benner's research indicates direction to limit lecture time. Group assignments, case studies and inter-professional simulation experiences should be utilized to augment hands-on clinical learning (Benner, 2012). Optimal preparation for initial licensure as a nurse, BSN completion and graduate level nursing education are all essential links in meeting the magnitude of health care challenges that are faced in this country (AACN, 2012). As today's complex health care environment continues to evolve, the impact of each nurse's academic preparation on patient outcomes is reiterated throughout nursing literature (Tanner, 2010). The concept of life-long learning has never been more applicable. Academic progression in nursing is no longer an option, it is a necessity. Impact on patient outcomes, as paired with projections for opportunities in nursing employment, makes that clear. Reports of hiring trends reiterate the need for progression. Nationally, hospital preference to hire nurses prepared at BSN and higher levels is reflected. American Association of Colleges of Nursing (AACN, 2012) data indicates that nation-wide 39% of hospitals require BSN preparation for new hires; 77% of hospitals indicate strong preference to hire BSN prepared nurses. Metropolitan areas in Missouri reflect such trends as well.

Historically, approximately 60% of the nursing workforce has been prepared at the ADN level. National Council of State Boards of Nursing (NCSBN, 2013) data shows that in 2011 57% of all first-time time testers taking the NCLEX-RN licensure exam were prepared at the ADN level. The Robert Wood Johnson Newsletter, published in September 2013, indicates that in 2012 53% of graduates from professional nursing programs were ADN prepared. Slight shift (approximately 4%) toward increase in BSN prepared graduates is indicated. Across the country significant increase in enrollment in RN to BSN completion programs is indicated. More nurses than ever are coming back to school to continue their education and gain desired degrees. AACN (2012) data indicates increase in RN to BSN enrollment from a little more than 30,000 in 2003 to nearly 90,000 students in 2011. The Robert Wood Johnson Newsletter (2013) indicates augmentation of enrollment to about 100,000 in 2012. While RN to BSN program enrollment is steadily growing, continued academic transformation of educational expectations, processes and experiences is necessary to progress toward the Institute of Medicine (IOM) goal for 80% of professional registered nurses to be prepared at BSN or higher levels by 2020. This goal was set by the IOM in 2010.

While efforts should be concentrated to facilitate seamless progression, expand options and eliminate needless repetition of course work, rigorous academic standards must be upheld. Otherwise, the projected paradigmatic shift necessary to keep nurses prepared to optimally support positive patient outcomes is truly jeopardized. Nurses have lots of options to complete desired degrees. The number of BSN completion programs has dramatically increased in recent years. AACN (2012) data captures at least 646 programs; 400 or more offer on-line components, some are completely on-line. Many more programs are in development and data is unclear on just how many schools offer or are preparing to offer BSN completion programs at this time. It is of utmost importance for nurses to carefully evaluate BSN completion options prior to enrollment. With so many options available, finding a school that provides optimal opportunities for progression, fits well with the nurse's schedule and offers course work that meets the nurse's needs is not always easy.

It is important to remember that Missouri State Board of Nursing (Board) jurisdiction is limited to pre-licensure nursing education; therefore BSN completion and nursing education programs at the graduate/doctoral level are not approved by the Board. When choosing a BSN completion program, many factors come into play. Personal and professional responsibility to choose a nursing program rests with the nurse. Questions to ask may include inquiry about the school's as well as the program's accreditation status, depth and rigor of required preparatory science course work, extent of learning experiences in clinical settings and course work designed to bring about deliberate progression in nursing knowledge and clinical expertise. Exploration of

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AGENDA

March 21, 2014

CROWNE PLAZA • ST. LOUIS AIRPORT • 11228 LONE EAGLE DRIVE • BRIDGETON, MO 63044

Conference Objectives

- Examine aspects of professionalism and compassion in the delivery and receipt of healthcare services in relation to individual health and well-being.
- Discuss a sociotechnical approach to improving healthcare quality and safety, addressing the social aspects of individuals within technical systems and processes.
- Discuss the impact of health information technology on the quality and safety of care delivery.
- Identify successful practices and processes for collaboration to improve healthcare quality and safety.
- Discuss the role of health literacy and clear understanding among healthcare professionals and patients for safety improvement.
- Examine how proven successful safety practices can be replicated.
- Discuss with industry leaders safety-of-care issues, applicable to any healthcare setting.

Recommended Audience

Healthcare consumers, executives, senior managers, physicians, nurses, pharmacists and other clinicians who lead or manage organizations or provide direct patient care in any healthcare setting and those who pay for care or establish healthcare policy. Leaders and caregivers from health system, hospital, home health, nursing home, pharmacy and other provider organizations and those from health plans, employers, insurers, and regulators will benefit from attending this conference.

Schedule of Events

7:30-9:00AM	**REGISTRATION & BOOK SIGNING:** *The Hidden Gifts of Helping*	**STEPHEN G. POST, PHD**
9:00-9:15AM	**CONFERENCE WELCOME**	
9:15-10:30AM	**KEYNOTE**	**STEPHEN G. POST, PHD**

Doing Good and Feeling Better: A Deeper Look at Professionalism in Health Care

Patients need healthcare professionals whose compassion provides the emotional and relational security that are so important in coping with illness. But new science also shows that clinicians and professionals who provide and support compassionate care feel happier and healthier, and stay in the healthcare professions longer. This is big news for anyone in the healthcare professions!

10:30-11:00AM	**BREAK**	**BOOK SIGNING, VENDORS, POSTERS**
11:00-Noon	**GENERAL SESSION**	**FACILITATED PANEL DISCUSSION**

Health Information Technology & Safety Improvement – True or False?

This session will discuss the challenges and benefits of health technology in delivering and receiving care and services from varying perspectives, including health information exchanges, academia, nursing, pharmacy and consumers.

Noon-1:00PM	**LUNCH**	**VISIT VENDORS, POSTERS, THOUGHT LEADER PRESENTATIONS**

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March 21, 2014

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Schedule of Events (continued)

1:00-2:00PM **AFTERNOON KEYNOTE** — **MICHAEL LEONARD, MD**, *Pascal Metrics*

Embedding Safety and Reliability as Organizational Values to Create Sustainable Safety Excellence.
This session will look at how human factors impact the safety and reliability of care and how knowledge and understanding of these factors can lead to sustainable excellence in healthcare leadership, management, delivery and support.

2:00-2:15PM **Break**

2:15-3:15PM **GENERAL SESSION** — **SAM PETTYJOHN, MPH**, *Health Literacy Missouri*

Changing Your Communication Climate, Improving Patient Outcomes
Effective communication is one of the most important elements in achieving safe, quality care. This session will address health literacy and measurement of the quality of organizational communication. Poor organizational communication strategies affect patient understanding and the use of health information. The Communications Climate Assessment Tool (CCAT), designed to address standards by several nationally recognized quality organizations, will be introduced as a means to evaluate seven areas that the National Quality Forum (NQF) measures of health disparities and cultural competence. When paired with a Health Environment Assessment, the CCAT can assist in demonstrating and tracking performance in nine areas related to communication and understanding of barriers to patient-centered care within any setting.

3:15-4:15PM **GENERAL SESSION** — **SCOTT GRIFFITH**, *Owner and Principal Collaborator, SG Collaborative Solutions, LLC*

The Collaborative Approach to Better Outcomes in Healthcare - Culture and Collaboration
This session will provide a new way of thinking for healthcare improvement, explaining why traditional approaches, even those from highly reliability organizations in other industries, may not yield the results we were expecting. A more nuanced understanding of complex systems and human behaviors is needed. During his presentation, Griffith will describe the Five Skills critical to an organization's success and how individual leaders play a vital role in the Just Culture change necessary to sustain performance improvement. He will give examples of how to combine evidence-based methods with the science of predictive risk modeling and intervention.

4:15-4:30PM **CONFERENCE WRAP UP AND DRAWINGS**

Safe Care Conference Planning Coalition Members:
Health Literacy Missouri • Missouri Board of Nursing • Missouri Board of Pharmacy • Healthcare Services Group

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2014

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opportunities for clinical application of advanced nursing concepts should be at the forefront of decision making processes when choosing the nursing program.

Institutional, regional and national nursing accreditation of a nursing program may become very important as students/nurses begin and continue their nursing education. Transferability/acceptance of nursing course work often hinges on such accreditations; employment in select settings may be impacted as well. While national nursing accreditation does not guarantee that the nursing program is a great fit for the student/nurse, it does imply that certain academic standards are maintained. Newer nursing programs may not have national nursing accreditation, but candidacy status toward accreditation may be indicated. Overall, it is important to do the necessary research, ask questions, and consider all options while proactively choosing a nursing program that fosters solid academic progression, best meets individual needs and offers financially responsible options.

On a different note, many efforts are in progress to expand nursing education options for Missouri citizens. As discussed in last year's Newsletters, funding established by the State of Missouri through legislative action and appropriation of funds continues to be utilized to foster nursing education. This year a third round of monies has been made available to Missouri nursing programs through the Nursing Education Incentive Program (NEIP). As many of you may know, this funding comes about through collaboration between the Missouri State Board of Nursing and the Missouri Department of Higher Education. Major grant focus on increase of physical and educational capacity of professional nursing programs is demonstrated. Seven (7) programs of professional nursing received funding in 2013. Since 2011 NEIP funding has contributed right at three (3) million dollars to foster nursing education in Missouri. Decisions related to grant awards have been made through collaboration between the Missouri State Board of Nursing and the Missouri Department of Higher Education. 2013 Nursing Education Incentive Program (NEIP) grant awards can be reviewed at Missouri Department of Higher Education website: http://www.dhe.mo.gov/NursingGrant.php

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Benner, P. (2012). Educating Nurses: A call for radical transformation – How far have we come? *Journal of Nursing Education*, 51 (4), 183-184

National Council State Boards of Nursing. (2013). *NCLEX-RN Data*. Retrieved from https://www.ncsbn.org/1232.htm

Robert Wood Johnson Foundation Newsletter. (2013). *Charting nursing's future – The case for academic progression: Why nurses should advance their education and the strategies that make this feasible* (September 2013. Issue Number 21) Washington, D.C.

Tanner, C. (2010) Transforming pre-licensure nursing education: Preparing the new nurse to meet emerging health care needs. *Nursing Education Perspectives*, 31 (6), 347-353

Know Your Nursing Practice Act continued from page 1

circumstances by the member of the applicant's or licensee's profession;

(6) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct, or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:

(a) Willfully and continually overcharging or overtreating patients; or charging for visits which did not occur unless the services were contracted for in advance, or for services which were not rendered or documented in the patient's records;

(b) Attempting, directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or discourage the use of a second opinion or consultation;

(c) Willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests, or nursing services;

(d) Delegating professional responsibilities to a person who is not qualified by training, skill, competency, age, experience, or licensure to perform such responsibilities;

(e) Performing nursing services beyond the authorized scope of practice for which the individual is licensed in this state;

(f) Exercising influence within a nurse-patient relationship for purposes of engaging a patient in sexual activity;

(g) Being listed on any state or federal sexual offender registry;

(h) Failure of any applicant or licensee to cooperate with the board during any investigation;

(i) Failure to comply with any subpoena or subpoena duces tecum from the board or an order of the board;

(j) Failure to timely pay license renewal fees specified in this chapter;

(k) Violating a probation agreement, order, or other settlement agreement with this board or any other licensing agency;

(l) Failing to inform the board of the nurse's current residence;

(m) Any other conduct that is unethical or unprofessional involving a minor;

[(6)**](7)** Violation of, or assisting or enabling any person to violate, any provision of sections 335.011 to 335.096, or of any lawful rule or regulation adopted pursuant to sections 335.011 to 335.096;

[(7)**](8)** Impersonation of any person holding a certificate of registration or authority, permit or license or allowing any person to use his or her certificate of registration or authority, permit, license or diploma from any school;

[(8)**](9)** Disciplinary action against the holder of a license or other right to practice any profession regulated by sections 335.011 to 335.096 granted by another state, territory, federal agency or country upon grounds for which revocation or suspension is authorized in this state;

[(9)**](10)** A person is finally adjudged insane or incompetent by a court of competent jurisdiction;

[(10)**](11)** Assisting or enabling any person to practice or offer to practice any profession licensed or regulated by sections 335.011 to 335.096 who is not registered and currently eligible to practice pursuant to sections 335.011 to 335.096;

[(11)**](12)** Issuance of a certificate of registration or authority, permit or license based upon a material mistake of fact;

[(12)**](13)** Violation of any professional trust or confidence;

[(13)**](14)** Use of any advertisement or solicitation which is false, misleading or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed;

[(14)**](15)** Violation of the drug laws or rules and regulations of this state, any other state or the federal government;

[(15)**](16)** Placement on an employee disqualification list or other related restriction or finding pertaining to employment within a health-related profession issued by any state or federal government or agency following final disposition by such state or federal government or agency;

[(16)**](17)** Failure to successfully complete the impaired nurse program;

(18) Knowingly making or causing to be made a false statement or misrepresentation of a material fact, with intent to defraud, for payment pursuant to the provisions of chapter 208 or chapter 630, or for payment from Title XVIII or Title XIX of the federal Medicare program;

(19) Failure or refusal to properly guard against contagious, infectious, or communicable diseases or the spread thereof; maintaining an unsanitary office or performing professional services under unsanitary conditions; or failure to report the existence of an unsanitary condition in the office of a physician or in any health care facility to the board, in writing, within thirty days after the discovery thereof;

(20) A pattern of personal use or consumption of any controlled substance unless it is prescribed, dispensed, or administered by a provider who is authorized by law to do so;

(21) Habitual intoxication or dependence on alcohol, evidence of which may include more than one alcohol-related enforcement contact as defined by section 302.525;

(22) Failure to comply with a treatment program or an aftercare program entered into as part of a board order, settlement agreement, or licensee's professional health program.

3. After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 621. Upon a finding by the administrative hearing commission that the grounds, provided in subsection 2 of this section, for disciplinary action are met, the board may, singly or in combination, censure or place the person named in the complaint on probation on such terms and conditions as the board deems appropriate for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit.
4. For any hearing before the full board, the board shall cause the notice of the hearing to be served upon such licensee in person or by certified mail to the licensee at the licensee's last known address. If service cannot be accomplished in person or by certified mail, notice by publication as described in subsection 3 of section 506.160 shall be allowed; any representative of the board is authorized to act as a court or judge would in that section; any employee of the board is authorized to act as a clerk would in that section.
5. An individual whose license has been revoked shall wait one year from the date of revocation to apply for relicensure. Relicensure shall be at the discretion of the board after compliance with all the requirements of sections 335.011 to 335.096 relative to the licensing of an applicant for the first time.
6. The board may notify the proper licensing authority of any other state concerning the final disciplinary action determined by the board on a license in which the person whose license was suspended or revoked was also licensed of the suspension or revocation.
7. Any person, organization, association or corporation who reports or provides information to the board of nursing pursuant to the provisions of sections 335.011 to 335.259 and who does so in good faith shall not be subject to an action for civil damages as a result thereof.
8. **[**If the board concludes that a nurse has committed an act or is engaging in a course of conduct which would be grounds for disciplinary action which constitutes a clear and present danger to the public health and safety, the board may file a complaint before the administrative hearing commission requesting an expedited hearing and specifying the activities which give rise to the danger and the nature of the proposed restriction or suspension of the nurse's license. Within fifteen days after service of the complaint on the nurse, the administrative hearing commission shall conduct a preliminary hearing to determine whether the alleged activities of the nurse appear to constitute a clear and present danger to the public health and safety which justify that the nurse's license be immediately restricted or suspended. The burden of proving that a nurse is a clear and present danger to the public health and safety shall be upon the state board of nursing. The administrative hearing commission shall issue its decision immediately after the hearing and shall either grant to the board the authority to suspend or restrict the license or dismiss the action.**] The board may apply to the administrative hearing commission for an emergency suspension or restriction of a license for the following causes:**

(1) Engaging in sexual conduct in as defined in section 566.010, with a patient who is not the licensee's spouse, regardless of whether the patient consented;

(2) Engaging in sexual misconduct with a minor or person the licensee believes to be a minor. "Sexual misconduct" means any conduct of a sexual nature which would be illegal under state or federal law;

(3) Possession of a controlled substance in violation of chapter 195 or any state or federal law, rule, or regulation, excluding record-keeping violations;

(4) Use of a controlled substance without a valid prescription;

(5) The licensee is adjudicated incapacitated or disabled by a court of competent jurisdiction;

(6) Habitual intoxication or dependence upon alcohol or controlled substances or failure to comply with a treatment or aftercare program entered into pursuant to a board order, settlement agreement, or as part of the licensee's professional health program;

(7) A report from a board-approved facility or a professional health program stating the licensee is not fit to practice. For purposes of this section, a licensee is deemed to have waived all objections to the admissibility of testimony from the provider of the examination and admissibility of the examination reports. The licensee shall sign all necessary releases for the board to obtain and use the examination during a hearing; or

(8) Any conduct for which the board may discipline that constitutes a serious danger to the health, safety, or welfare of a patient or the public.

9. The board shall submit existing affidavits and existing certified court records together with a complaint alleging the facts in support of the board's request for an emergency suspension or restriction to the administrative hearing commission and shall supply the administrative hearing commission with the last home or business addresses on file with the board for the licensee. Within one business day of the filing of the complaint, the administrative hearing commission shall return a service packet to the board. The service packet shall include the board's complaint and any affidavits or records the board intends to rely on that have been filed with the administrative hearing commission. The service packet may contain other information in the discretion of the administrative hearing commission. Within twenty-four hours of receiving the packet, the board shall either personally serve the licensee or leave a copy of the service packet at all of the licensee's current addresses on file with the board. Prior to the hearing, the licensee may file affidavits and certified court records for consideration by the administrative hearing commission.

10. Within five days of the board's filing of the complaint, the administrative hearing commission shall review the information submitted by the board and the licensee and shall determine based on that information if probable cause exists pursuant to subsection 8 of this section and shall issue its findings of fact and conclusions of law. If the administrative hearing commission finds that there is probable cause, the administrative hearing commission shall enter the order requested by the board. The order shall be effective upon personal service or by leaving a copy at all of the licensee's current addresses on file with the board.

11. (1) The administrative hearing commission shall hold a hearing within forty-five days of the board's filing of the complaint to determine if cause for discipline exists. The administrative hearing commission may grant a request for a continuance, but shall in any event hold the hearing within one hundred twenty days of the board's initial filing. The board shall be granted leave to amend its complaint if it is more than thirty days prior to the hearing. If less than thirty days, the board may be granted leave to amend if public safety requires.

(2) If no cause for discipline exists, the administrative hearing commission shall issue findings of fact, conclusions of law, and an order terminating the emergency suspension or restriction.

(3) If cause for discipline exists, the administrative hearing commission shall issue findings of fact and conclusions of law and order the emergency suspension or restriction to remain in full force and effect pending a disciplinary hearing before the board. The board shall hold a hearing following the certification of the record by the administrative hearing commission and may impose any discipline otherwise authorized by state law.

12. Any action under this section shall be in addition to and not in lieu of any discipline otherwise in the board's power to impose and may be brought concurrently with other actions.

Literature Review: Nurse Fatigue Related to Shift Length

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The issue of nurse fatigue is of increasing concern to nurses and healthcare organizations. Evidence to document the fatigue issue continues to emerge and provide more specific data and insights for the healthcare community. The relationship of fatigue to patient safety and risk of self-injury is documented in several sources. The purpose of this literature review is to present the most recent evidence and recommendations specific to nurse fatigue for nurses and their managers in understanding these relationships.

Symptoms of fatigue include, but are not limited to decreased alertness, irritability and sleepiness. The Occupational Safety and Health Administration (OSHA)[1] cautions against working more than 8-hour shifts as longer shifts may results in reduced alertness. Fatigue is correlated to nurse performance and chronic fatigue is related to the number of hours worked.[2]

Health care workers are not alone in shift work and working long hours. The Department of Transportation regulates the number of hours of service for those in aviation, highway, rail and nautical professions.[3] Not only are shift times regulated; some have restrictions on weekly and monthly work allotments. Sleep and rest are noted to be important for those in the rail industry[4], airline industry[5], and the forest industry.[6]

Long working hours may have an impact on errors as well as near errors,[7] and decrease the nurse's vigilance in critical care.[8] Research conducted by Barker and Nussbaum (2011) found that acute fatigue resulted from long hours of work, and that fatigue was negatively correlated with performance.

It was identified that an increased number of shifts worked by nurses in the prior 72 hours were significantly associated with hypoglycemic events in ICU patients receiving insulin infusions.[9] Documentation of patient care can also be impacted by working longer hours; there were 26 percent less charting errors with fewer call hours in the surgical setting.[10]

In addition to patient clinical outcomes, a correlation exists between hospitals where nurses worked 13 hours in length or longer and patient dissatisfaction with communication, pain control and help when they wanted it.[11] Nurses working long shifts were more likely to be burned out, dissatisfied with their job and intended to leave their job within the year.[11, 12] Shifts scheduled for 12 hours often exceed that timeframe, as many as 40% of the work shifts logged for their study exceeded 12 hours.[7]

Nurse's personal safety related to longer worked hours is also a concern. Extended work hours are a contributing factor in needle stick injuries among nurses,[13] and rates of nurses driving drowsy doubled when they worked more than 12.5 hours.[14] In a study that examined the impact of a 9-hour shift compared to an 8-hour shift, the nurses working the 9-hour shift had more health issues, were not as satisfied and had more fatigue.[15] In variables associated with worker injury, those working 12-hour shifts had a higher medical cost per injury than those who worked 8-hour shifts.[16] Findings in a simulated environment demonstrated older people were not able to perform as well as younger people.[17] This is important for the health care industry to consider as the nursing workforce ages and there is a need to retain them through improved job attributes.[18]

If shorter shifts are not available, planning to decrease the effects of fatigue can include regular and frequent breaks,[1, 7, 19, 20] meal breaks,[1, 7, 19] staff getting enough sleep or naps,[21, 22, 19, 23] limiting caffeine,[19, 23] eating well and exercising[19] and limit the number of shifts worked in a row.[20] Additional options include avoiding double back shifts such as an evening shift followed by a day shift with less than eight hours between, limit on-call hours, and allow sleeping during the night shift. Implementation of a formal fatigue countermeasures program for nurses has provided evidence of improvement in nurse fatigue.[24] With consecutive 12-hour shifts, nurses were not able to recover between shifts and used caffeine as a possible mechanism to improve alertness.[25]

It is a legal and ethical obligation to educate the nursing staff about the effects of long work hours.[26] It is important for senior management to be aware of the impact of working longer shifts.[27] The Institute of Medicine (IOM)[28] recommends limiting the number of hours worked in a day by nurses as a patient safety precaution. They find the evidence to be "very strong" (p. 236) related to prolonged work hours and worker fatigue. Recommendations are that health care organizations establish policies and practices to limit hours worked in a shift as well as the number of hours worked in a week,[11, 28] that the "routine use of twelve-hour shifts should be curtailed"[7] (p. 210), and that overtime after a 12-hour shift should be eliminated.[7] Another recommendation is to decrease shift length to allow recovery time between shifts.[29] Health care workers in the United States often work 12-hour shifts prompting Lockley[30] to state "hours routinely worked by health care providers in the United States are unsafe" (p. 14). The American Nurses Association[31] notes that in addition to employee accountability regarding fatigue, employers are obligated to provide adequate staffing to care for patients. It is not the individual nurse's responsibility to cover all shifts by working extra hours.

The evidence is compelling that long shift lengths are correlated with negative outcomes for both patients and nurses. Patients are impacted by errors in their care and are more dissatisfied when nurses work longer shifts. For the nurse, the outcomes of working longer shifts can be injury to self and intent to leave their job. Injuries may happen on the job such as needle sticks or strains; or on the way home if in an accident caused by driving while drowsy.

A literature review reveled that shift length has been correlated with nurse fatigue and has become a growing concern in the United States with the routine shift length of 12 hours. Outcomes correlated to shift length and fatigue includes errors or near errors in patient care. In addition to concerns in patient care outcomes, the impact of fatigue on the nurse is also noted.

Nursing is a profession, and as a profession, we need to be self-regulating. If we are not able to mitigate the impact of fatigue, it could become regulated as with other industries such as transportation, logging and nuclear power workers.

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The Implications of Nurse Fatigue

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Nurse Fatigue

It is estimated that approximately 38% of the U.S. workforce is fatigued and more than 40 million Americans suffer from some type of sleep disorder. Over 85 sleep disorders have been identified and some of those include: acute or chronic insomnia; restless leg syndrome; narcolepsy; sleep apnea; and shift work syndrome. The fatigued worker is often lacking in self-awareness of the level of impairment they are experiencing (Zhou, 2011). Workers who experience continuous wakefulness of 21 hours or more have functional scores that are similar to a blood alcohol concentration of 0.08% (Arnedt, 2001). Nurses experience fatigue and physical exhaustion, which can be exacerbated by working nights and 12-hour shifts. It is not uncommon for nurses and other night shift workers to fall asleep while on the job (Rogers, 2008).

Definitions

Fatigue is a feeling of weariness, tiredness, or lack of energy (Lerman, Flower, Gerson, & Hursh, 2012). Sleepiness, a tendency to fall asleep, often coexists with fatigue (Rogers, 2008). Nurse fatigue must not be confused with *compassion fatigue*, which is defined as a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress (Figley, 1995). *Stress* is a condition or feeling experienced when a person perceives that demands exceed the personal and social resources the individual is able to mobilize (Stress Management – Start Here!, 2013). *Burnout* is a special type of job stress consisting of a state of physical, emotional or mental exhaustion combined with doubts about competence and the value of one's work (Job burnout: How to Spot It and Take Action, 2012). *Nurse fatigue* can be described as fatigue affecting the nurse population that may result from the following contributing factors: working long shifts in the health care workplace; obtaining insufficient sleep between scheduled shifts; a disturbance in circadian rhythms; and attempting to balance demanding personal, familial, and social obligations in addition to the work schedule.

Background

Nurse Fatigue is especially concerning for health care organizations because it can result in unsafe or hazardous conditions that may jeopardize patient safety, as well as the safety of the nurse, especially when driving (Rogers, 2008). However, nurse fatigue can be managed like many other types of risk factors. Nurses and employers need to be educated on the hazards of working while fatigued and the benefits of coming to work well rested. Strategies can be established in the workplace to identify a fatigued nurse and to mitigate the consequences for the organization and the nurse.

Evidence from the nursing literature emphasizes the detrimental effect fatigue has on the well-being of nurses and patient outcomes. Nurse fatigue may lead to a variety of adverse medical problems, burnout, errors, and patient dissatisfaction. Worker fatigue studies are more prevalent in the aviation, trucking, manufacturing, military, medical, and nuclear power plant industries (Hursh, 2004; Lerman et al., 2012). The nursing profession can benefit from these research findings as each of these industries have 24/7 operations. There is a need for more nursing research to fully explore the implications of nurse fatigue.

Arizona Nurses Association Action Proposal

Nurse Fatigue was identified by the membership of the Arizona Nurses Association (AzNA) in 2011 as an issue for concern and was developed into an action proposal. According to the findings at the time the proposal was written:

1. The likelihood of making an error is three times higher with >12.5 consecutive hours of nursing practice (Rogers, 2008).
2. Errors are increased with overtime or working over 40 hours per week (ANA Policy Mandatory Overtime, n.d.).
3. Less than 50% of work breaks are away from patient care (AHRQ, 2005).
4. Night shift workers may have difficulty staying awake due to disturbance in circadian rhythms (Dagan, 2002).
5. The majority of errors from fatigue are medication errors (Rogers, 2008).
6. Sleep deprivation is linked to increased deviation from standard practice and unintentional sleep at work (Scott, 2006).
7. Drowsiness while driving is related to inadequate sleep, night shift work, and difficulty with wakefulness at work (Rogers, 2008).

The Professional Issues Steering Committee (PISC), a task force of elected AzNA members, was assigned to address the action proposal. The committee decided to administer an electronic survey to assess members' fatigue-related concerns and the survey was distributed via email in December 2012.

Nurse Fatigue Survey

The Nurse Fatigue Survey was administered as a confidential, electronic survey that included a demographics section and 17 items for response. The survey was active for three weeks and closed on January 15, 2013. There were 1,004 Arizona registered nurses (RNs) who responded. The targeted audience was RNs whose primary responsibility was direct patient care.

The majority of respondents were Baby Boomers (47%) and 42% were BSN prepared. The majority of nurses worked on the day shift (71%), 37% had greater than 20 years of nursing experience, and 69% worked 12-hour shifts. Eighty percent (80%) of respondents recognized their inability to concentrate at work and driving on the road was compromised when fatigued. They feared making mistakes and acknowledged drowsiness while driving; 28% experienced drowsiness behind the wheel at all times. The number of hours of sleep varied and 52% were concerned or seriously concerned about the number of hours they slept; 62% slept 6-7 hours and 33% reported sleeping 4-5 hours between shifts. In addition to quantity of sleep, the quality of sleep was also problematic; 33% of nurses reported sleep quality as poor or very poor and 33% used some form of prescription medication or over-the-counter preparation as a sleep aid most days of the week. Additional survey results are detailed in Table 1 and Table 2:

Table 1. 2012 AzNA Nurse Fatigue Survey Responses Related to Sleep

	4-5 hours %(#)	**6-7 hours %(#)**	**8-9 hours %(#)**	**>10 hours %(#)**
Hrs of sleep between shifts	26.1% (260)	62% (619)	11.3% (113)	0.6% (6)
	Seriously %(#)	**Moderately %(#)**	**Mildly %(#)**	**No ne %(#)**
Level of concern about adequacy of sleep	14.5% (144)	37.6% (374)	32.3% (321)	15.7% (156)
	Very Poor %(#)	**Poor %(#)**	**Fairly Good %(#)**	**Good %(#)**
Quality of Sleep	3.5% (35)	30% (301)	53.7% (538)	12.6% (128)
	Yes		**No**	
Use of Meds to Sleep (OTC and Rx)	36.6% (364)		63.4% (630)	
	Daily %(#)	**2-3 times a week %(#)**	**Few times a month %(#)**	**Rare %(#)**
Frequency of med use for those who use meds to assist with sleep (387 answered 619 did not answer)	26.4% (102)	32.6% (126)	27.4% (106)	13.7% (53)

Table 2. 2012 AzNA Nurse Fatigue Survey Responses Related to Fatigue Affect

	Seriously %(#)	**Moderately %(#)**	**Mildly%(#)**	**No ne %(#)**
Level of concern about error due to fatigue	14.1% (139)	26.6% (263)	39.2% (387)	20.1% (199)
	All of the Time %(#)	**Most of the Time %(#)**	**Sometimes %(#)**	**Never %(#)**
Frequency of feeling drowsy when driving after work	7.0% (70)	21.1% (210)	53.6% (533)	18.3% (182)
	All of the Time %(#)	**Most of the Time %(#)**	**Sometimes %(#)**	**Never %(#)**
Concern about ability to concentrate at work being compromised due to fatigue	0.3% (3)	5.0% (50)	75.5% (752)	19.2% (191)

Fatigue Risk Model

The Moore-Ede fatigue risk model was used as a framework to understand the fundamentals of a fatigue risk management system. According to Moore-Ede (2009), there are five defenses that need to be managed:

1. Workload-staffing balance
2. Shift scheduling
3. Employee fatigue training and sleep disorder management
4. Work place environment design
5. Fatigue monitoring and alertness for duty.

The model features a feedback loop to help analyze fatigue-related errors and strengthen defenses to ensure continuous improvement. Use of a fatigue risk management system is considered a best practice (Lerman et al., 2012).

Symptoms of Fatigue and Performance Impairment

Fatigue can produce a variety of physiological, cognitive, and emotional symptoms that may be detrimental to quality of life, well-being, and performance on the job.

Physiological symptoms. Physiological symptoms of fatigue may include excessive yawning, drooping eyelids, rubbing of the eyes, head dropping, and finally succumbing to uncontrollable sleep in the form of microsleep, naps, or longer sleep episodes. Physical symptoms may also include digestive problems and speech effects affecting the rate and content of speech. Manual dexterity may also be reduced affecting activities such as key-punch entry and switch selection resulting in errors. Some of the symptoms are easy to recognize in oneself or others; however, cognitive and emotional symptoms are less easily recognized.

Cognitive symptoms. Cognitive signs of fatigue may include difficulty concentrating on tasks, lapses in attention, difficulty remembering tasks being performed, and failing to communicate important information. Nurses who are fatigued may fail to anticipate events or actions. They may accidentally take the wrong action or inadvertently fail to do the right thing. Reaction time may be compromised and the fatigued nurse may respond slowly or fail to respond at all to normal, abnormal, or emergency stimuli. These symptoms are linked to performance impairment and often there is a lack of awareness of a decline in cognitive functioning. The impaired employee may not anticipate danger and display decreased vigilance. Logic may become flawed, the individual may have problems with cognitive processing tasks such as mathematics, or there may be a failure to accurately interpret a situation. Additionally, there may be poor judgment of distance, speed, and time.

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Emotional symptoms. Emotional symptoms may be manifested by an unusually quiet or withdrawn demeanor, or a lack of energy and or motivation to perform tasks. Mood may be affected and others may notice the nurse is less conversant than normal, irritable, or apathetic, especially about performing low-demand tasks. Attitude may also be affected and may be manifested by a willingness to take risks or ignoring normal safety checks or procedures.

Long-term disorders. Chronic conditions associated with fatigue are: chronic fatigue syndrome; fibromyalgia; sleep apnea; anxiety; depression; irritable bowel syndrome; obesity; metabolic syndrome; diabetes; and cancer.

Countermeasures

A number of countermeasures or interventions have been implemented to mitigate worker fatigue and could be considered as having potential benefit for nurses in the health care industry. Countermeasures can include: bright lighting; cool temperature; social interactions; physical activity; and strategic use of caffeine. When possible, a short nap break can significantly improve function. A prophylactic nap lasting 2-8 hours taken during the day prior to working at night combined with strategic use of caffeine 200 mg. at crucial times of 1:30 a.m. and 7:30 a.m. further enhances performance (Bonnet, 1994).

Screening for sleep disorders. Sleep disorders are common among shift workers. Mechanisms to manage sleep disorders begin with screening techniques. This could include a questionnaire such as the Epworth Sleepiness Scale (Johns, 1991) or the use of a device such as an actigraph worn on the wrist with computer-based computational support for calculating fatigue levels and determining fitness for work. One such tool was developed with the Department of Defense and is known as the Fatigue Avoidance Scheduling Tool (FAST). FAST calculates five fatigue factors: 1) chronic sleep debt; 2) recent sleep in the past 24 hours; 3) time since awakening; 4) time of day; and 5) circadian rhythm desynchronization at any point in a schedule that contributes to the predicted performance score. The tool also provides a scale that gives an equivalent to blood alcohol levels of 0.05%-0.08% (Hursh, 2004).

Sleep studies. Some sleep disorders require assessment and treatment by a health care provider. If disordered sleep is determined to be problematic, a sleep study is warranted. A sleep study can identify narcolepsy, restless leg syndrome, and sleep apnea as well as other sleep-related problems. With the sleep problem identified, interventions can be targeted to improve the quantity and quality of sleep. For the individual experiencing disordered sleep, adhering to the use of intervention modalities sometimes requires support and monitoring. Sleep apnea treatment with Continuous Positive Airway Pressure (CPAP) machines can be monitored by periodically downloading information collected from the device (Lerman et al., 2012). The wrist-worn actigraph with FAST software is another tool for determining fatigue management success.

Sleep hygiene. One of the best ways to prevent fatigue is by practicing good sleep hygiene measures. Most people require seven to nine hours of sleep each day so it is essential that nurses allow sufficient time for sleep. Avoiding heavy meals and alcohol before sleep, reducing caffeine intake, and limiting other stimulants several hours before bedtime should make it easier to fall asleep. The sleep environment should be very dark, comfortable, quiet, and cool to facilitate falling asleep quickly and staying asleep. A daily exercise routine that provides regular physical activity will improve sleep, help with stress management, and promote general health.

Insomnia applications for smartphones. Advanced technology now offers a number of insomnia applications available for purchase for smartphones that may be helpful for individuals having difficulty falling asleep or staying asleep. Sleep proceeds through stages from light to deep sleep forming cycles lasting 90-120 minutes. These cycles repeat approximately five times lasting 90-120 minutes. The phase of sleep an individual is in when their alarm goes off significantly impacts how tired he or she feels when awakening. Individuals move differently through the stages of sleep. One application tracks movement during sleep and determines which phase the individual is in to determine the best time to waken the individual during a 30-minute time frame that ends at the set alarm time. This application also saves sleep data and offers a detailed sleep graph and accompanying statistics to analyze sleep issues with a sleep specialist. Another application plays relaxing sounds of nature or ambient music and can combine them all at different volumes. This application also offers a customizable option to combine personal music with existing sounds or interactive photographs to enhance the experience on sleepless nights. Other applications provide audio content consisting of relaxation sleep sessions or comforting words and relaxing, guided meditations by hypnotherapists designed to de-stress and discover an inner calm that is conducive to sleep.

Lighting. Workplace lighting needs are different during the day and night shifts because of the sensitivity of the human circadian system to nocturnal light. The need for lighting during the night shift is more complex than during the day. Recent research has demonstrated that many of the adverse effects are due to the narrow band of the light spectrum between 470 and 480 nm. The human visual spectrum ranges from violet (380 nm.) to red (700 nm.). There is mounting evidence that exposure to light at night when combined with frequent circadian rhythm disruption can be a risk factor for adverse health effects such as cancer, heart disease, and metabolic disturbances (Lerman et al., 2012). Special eyeglasses were found to have beneficial effects in nurses when the sub-480 nm. light wavelength was filtered out improving alertness, sleep, and mood (Lerman et al., 2012).

Chemical Sleep Aid Use Requires Caution

Chemical sleep aids may include over the counter preparations such as diphenhydramine, melatonin, or cold and flu remedies. These preparations may be perceived as benign; however, they have adverse effects and some can be especially dangerous when combined with alcohol or other CNS depressants due to their sedative or antihistaminic effect. Others may have abuse potential. Prescription medications for sleep may include sleeping pills, some of which are associated with serious reactions such as hallucinations and abnormal dreams. Other prescription medications such as benzodiazepines, antihistamines, and tricyclic antidepressants may produce sedation but they also have adverse effects. Addiction potential should always be considered before initiating certain medications.

Employer Role in Promoting Healthy Nursing Work Hours

The responsibility for fatigue risk management is shared by employers and the individual employee (Lerman et al., 2012). The American Nurses Association (2006) published a position statement that recommended employers of RNs should ensure sufficient resources to provide a work schedule that offers time for adequate rest and recuperation between scheduled shifts. Employers can provide the opportunity for short naps in quiet secluded areas adopting a strategy employed by the airline industry to assure alert pilots for long haul flights. Additionally, sufficient compensation and appropriate staffing systems are needed that foster a safe and healthful environment in which RNs do not feel compelled to seek supplemental income through overtime, extra shifts, and other practices that contribute to worker fatigue. Employers can encourage nurses to provide caring vigilance of co-workers helping to identify behaviors or symptoms that indicate fatigue and could place themselves and others at risk. Nurses need to have each other's back.

Nurse Responsibility and Role in Avoiding Fatigue

According to the ANA Code of Ethics for Nurses (2001), the nurse's primary responsibility is to the patient whether it is an individual, a family, a group, or the community. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient. The nurse's obligation extends to his or her own decision-making and that of other members of the health care team. The nurse must consider when fatigue is impacting professional judgment and decision-making of any member of the health care team and whether fatigue may possibly be placing the patient at risk.

Regulatory Statements on Health Care Worker Fatigue

The Joint Commission issued Sentinel Event Alert 48 in 2011 and brought recognition to the dangers of extended work hours emphasizing that the health care industry has been slow to adopt changes, particularly with regard to nursing. The Joint Commission (2011) recommends the creation and implementation of a fatigue management plan with strategies such as:

1. Actively engaging in conversations with others
2. Doing something that involves physical action (e.g. stretching)
3. Consuming caffeine
4. Taking short naps less than 45 minutes in length
5. Maximizing success by trying different combinations of strategies
6. Counteracting severe consequences by obtaining adequate sleep

Summary

As a result of the 2011 Nurse Fatigue Action Proposal, AzNA generated a nurse fatigue survey and disseminated the findings through presentations, publication of articles, and a continuing education module for contact hours that will be posted on the AzNA website this year. Fatigue is pervasive among nurses who work on all shifts resulting in serious consequences for the safety of patients and the safety and well-being of nurses. There is mounting evidence to suggest that 12-hour shifts and working over 40 hours per week contributes to fatigue and drowsiness. This has a direct impact on nurse performance and patient safety (Rogers, 2008). As a result, it is strongly recommended that nurses protect their sleep time between shifts and strive to achieve a minimum of seven to eight hours per 24 hours. Nurses must also be vigilant of their co-workers who demonstrate signs of fatigue and intervene when necessary. An organizational culture of safety that supports the physiological needs for rest among health care providers will enhance performance and improve patient safety. One recommendation for employers is creating opportunities for rest breaks in a quiet space for nurses. Education and awareness about the dangers of nurse fatigue for nurse leaders and RNs in hospital organizations will contribute to a healthier work environment and a safer environment of care for patients.

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Implications of Nurse Fatigue continued on page 10

Introducing an Innovative Nurse Licensure Notification System

nursys® E-NOTIFY

Typically, when employers want to know if a nurse's license is about to expire, they have to look it up one nurse at a time. When it comes to learning about discipline status, employers must seek this information on their own as well.

Not anymore.

With NCSBN's Nursys® e-Notify system, institutions that employ nurses now have the ability to receive automatic licensure and discipline notifications quickly, easily and securely. Nursys® e-Notify is an innovative nurse licensure notification system that automatically provides employers licensure and publicly available discipline data as it is entered into Nursys by boards of nursing (BONs). Employers don't have to proactively seek licensure or discipline information about their nurses because that information will be sent to them automatically.

The e-Notify system alerts subscribers when modifications are made to a nurse's record, including changes to:

- License status;
- License expirations;
- License renewal; and
- Public disciplinary action/resolutions and alerts.

For example, if a nurse's license is about to expire, the system will send a notification to the employer about the expiration date. If a nurse was disciplined by a BON, his/her employer will immediately learn about the disciplinary action, even receiving access to available public discipline documents.

Understanding Nursys®

The information in e-Notify is pulled directly from Nursys, the only national database for licensure verification, discipline and practice privileges for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). Nursys data is compiled from information directly entered by BONs (in participating jurisdictions; visit nursys.com for current participation list).

Cost

All institutions are given 100 nurse enrollments free of charge. This means that the first 100 nurses enrolled in the system are free. After that, each nurse is $1 per nurse, per subscription year. A facility that employs 25 nurses would pay nothing to utilize e-Notify; a facility with 150 nurses would pay $50 per year.

A unique feature of e-Notify is the ability for institutions to turn a nurse's notification setting on or off, choosing whether or not to receive notifications about a specific nurse's licensure or discipline status. Only nurses who have their notifications turned on are charged against the employer's 100 free enrollments. If a nurse takes a leave of absence and an institution turns off his/her notification, they can employ someone to take his/her place during that time and still only use one nurse enrollment. If the institution chooses not to turn off the notification of the nurse on leave, they will only pay an additional $1 for the replacement nurse enrolled.

Ease of Use

Institutions can enroll nurses into e-Notify easily, either individually or through bulk process; all that is needed is the nurse's license number, license type and the state that issued the license. This information is needed to match the nurse in the system; your data is not stored in e-Notify. Once nurses are matched and enrolled, institutions can access their nurse list and run reports at any time.

Institutions have the option of sending automatic license renewal email reminders, as well as text messages, to their nurses. In addition, institutions can also determine how often they want to receive email notifications about their nurses: either daily, weekly or monthly.

With Nursys® e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or no charge. Nursys® e-Notify provides real-time automatic notification of status and discipline changes delivered directly to institutions. It's an invaluable tool that provides vital information to employers, saving them money and staff time, as well as providing better public protection.

Employers can learn more about Nursys® e-Notify by viewing an introductory video or visiting the Nursys website. For questions, contact nursysenotify@ncsbn.org or call 312.525.3780.

Nurse Imposter Alert

Employers in the Metro St Louis area please beware of an individual identified as Dana R Reinhardt, Caucasian female, DOB 06-04-76, attempting to obtain employment as a nurse by falsely using the credentials and license number of a registered professional nurse (RN) who is licensed in Missouri. Dana Reinhardt is presenting herself as an RN, licensed in the state of Missouri, under the valid license of 121111 which belongs to someone bearing the name of Diane D. Reinhardt. Dana Reinhardt possesses a valid Illinois driver's license and her last known address is 401 Mockingbird Lane, Waterloo, Ill. Dana R. Reinhardt, DOB 06-04-76, is **not** a licensed nurse in the State of Missouri.

Implications of Nurse Fatigue continued from page 9

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The Board of Nursing is requesting contact from the following individuals:

April Hasenzahl–RN2009008893
Ashley Hurley–PN2003016522
Larry Lavender–RN2012004237
Gaile Maddux-Wolfguts–RN109555
Melinda Novak–PN055876
Sherri Pelecanos–RN069541
Keisha Stone–RN2004006343
Candie Wilkins–PN2004026358

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

CENSURE

Bender, Corinne S.
Nevada, MO
Licensed Practical Nurse 040280
On February 19, 2012, Licensee arrived at the facility and began her shift as a charge nurse in the Alzheimer's unit, and had many residents assigned to her care. During her shift that morning, licensee approached male resident J in the dining room who had been diagnosed with Alzheimer's and began to tell him he needed to take a shower. When J voiced his unwillingness to take a shower, licensee began to argue with him. When J (who was seated in a dining room chair at his table) still refused to go, Licensee then proceeded to remove J's shoes, socks, pants, watch and eyeglasses in full view of other residents in the dining room. J tried to push away licensee as she did so. J then remained in full view of other residents and CNA's with only a pull-up diaper and shirt on. Licensee then dragged the dining room chair with J in it out of the dining room into the hall to a set of doors that go into another part of the facility. As licensee was dragging the chair through the door with J in it, J grabbed the door edges. Licensee pried J's hands loose in order to further pull the chair through the doors. Shortly after this occurred, licensee was confronted by facility officials who instructed her to clock out and leave the facility. Licensee was initially suspended from employment from the facility and later terminated from employment as a result of the above conduct. Licensee's conduct violated the facility's policies. Licensee admitted to the Board's investigator that she had removed J's pants in the dining room and that it was "not common" to do that.
Censure 10/18/2013 to 10/19/2013

Heck, Thomas Jacob
Lees Summit, MO
Registered Nurse 2002005630
Pharmacy reports were ran from April 1, 2011 through April 22, 2011. Licensee was discovered to have removed Hydromorphone on seven patients that did not have orders for Hydromorphone. Licensee documented the administration of Hydromorphone to the seven patients that did not have an order for Hydromorphone. Administering Hydromorphone without an order is outside the scope of practice of a registered nurse.
Censure 09/04/2013 to 09/05/2013

Johnson, Sharon Sue
Jefferson City, MO
Licensed Practical Nurse 012642
Licensee practiced nursing in Missouri without a current valid license from June 1, 2012 through September 5, 2013.
Censure 10/24/2013 to 10/25/2013

Gokenbach, Virginia H.
Cadet, MO
Registered Nurse 082873
On April 6, 2012, Licensee charted that she performed an assessment on a patient which she did not actually perform.
Censure 11/20/2013 to 11/21/2013

Franseen, Patricia G.
Kansas City, MO
Registered Nurse 067644
Licensee worked from May 1, 2011 - May 23, 2013 on an expired nursing license.
Censure 11/29/2013 to 11/30/2013

CENSURE continued...

Harrison, Paula Jo
Jefferson City, MO
Registered Nurse 2008024149
Respondent failed to submit a chemical dependency evaluation by the documentation due date and submitted a sample for testing with a low creatinine level, which is considered dilute and a failed urine test.
Censure 09/24/2013 to 09/25/2013

Randall, Laura M.
Joplin, MO
Registered Nurse 137105
Resident SM lived at the facility, and licensee developed a relationship of professional trust and confidence with SM, other patients, her colleagues and other staff. Licensee drove SM to a bank wherein SM withdrew $800.00 and licensee accepted $800.00 from SM in order to repair her car.
Censure 11/19/2013 to 11/20/2013

Gilliland, Gina R.
Atlanta, MO
Registered Nurse 120873
Respondent failed to call in to NTS on five separate (5) days. On two separate occasions Respondent reported to the lab as requested and submitted the required samples which showed low creatinine readings.
Censure 11/05/2013 to 11/06/2013

Bullard, Bradford L.
Ashland, MO
Licensed Practical Nurse 058657
On January 7, 2013, Licensee was on duty and was aware that patient DG was in seclusion at the hospital. Licensee was asked to assist a co-worker with an assessment of DG. Licensee then proceeded to stand in the doorway of DG's seclusion room. Licensee began a conversation with DG in which staff and other patients were present in which Licensee stated to DG: "I bet you're ready for a shower, I can smell you through the door, can't I?" "Well, I think you need to wash your body because it smells", and "If you were a dog, I'd shoot you." Licensee's comments demeaned and belittled DG. DG cried after hearing licensee's comments. Licensee admitted to hospital officials and to the Board's investigator that he made the comments to DG. Licensee's conduct violated the hospital's policies. Licensee's employment ended when he resigned in lieu of termination by the hospital as a result of these events, on April 17, 2013.
Censure 10/23/2013 to 10/24/2013

Parker, Deborah A.
Kansas City, MO
Registered Nurse 065965
Respondent worked on a lapsed license in Missouri from 05-01-2011 - 04-23-2013.
Censure 11/05/2013 to 11/06/2013

CENSURE continued...

Surface, Carrie Layne
Jackson, MO
Licensed Practical Nurse 2010036651
On October 25, 2011, licensee was counseled for ordering an MRI on the wrong patient as a result of misinterpreting a physician's orders. This same patient's order also contained an order from the physician for the prescription of Valium to be called in and licensee did not do so. On November 9, 2011, licensee was counseled for telling a patient that had called in with rectal bleeding that the patient would have to address it in a physical scheduled to occur in one month. Licensee was counseled on the need to triage urgent problems and schedule them appropriately. On November 11, 2011, licensee was counseled for telling a patient's father which patient had a knot on his arm and a history of cancer that he would have an appointment in January, 2012, a time frame of approximately two months later. Licensee was counseled again on the need to triage urgent problems and schedule them appropriately. On December 30, 2011, licensee was counseled for failing to label specimen containers, resulting in an inability for the lab to conduct the required tests on a pap smear, resulting in a patient having to return to have another pap smear. On January 9, 2012, licensee received a written warning that she had continually not identified patients with a date of birth in violation of policies. On June 12, 2012, licensee was counseled when a patient under the care of an oncologist exhibited wheezing symptoms and licensee did not timely bring the matter to a physician's attention resulting in the patient not getting an immediate appointment. On July 9, 2012, licensee was counseled for putting the wrong patient name and date of birth on a patient message resulting in the physician ordering the incorrect medication for the patient. On July 10, 2012, licensee was suspended from employment for violating policies by placing a soiled dressing in a sink

Censure continued on page 12

Censure continued from page 11

which was a clean area, and when informed to remove it, did not properly dispose of it. Licensee's employment was terminated on July 24, 2012 as a result of the above actions and as a result of on that date of cancelling a patient's appointment off the schedule incorrectly, resulting in the patient not seeing the physician when contemplated.
Censure 09/24/2013 to 09/25/2013

Goodman, Crystal Dawn
Kennett, MO
Registered Nurse 2007016993
On December 13, 2010, the floor was staffed by Licensee and a nurse aide. Licensee repeatedly volunteered to leave the floor to give a patient, her brother-in-law, on a different floor, Demerol, a controlled substance pain medication. On December 13, 2010, while on duty, Licensee called her manager, asking to go home because she was sick with a stomach virus. Licensee's speech at the time of the telephone call was slurred and unintelligible. Licensee's manager contacted the house supervisor on duty. The on duty house supervisor observed Licensee with her head on the desk. Licensee's eyes were closed. Licensee's movements were lethargic, and her speech was slurred. Licensee struggled to answer simple questions and had to be continually aroused by hospital staff to complete her work. Three registered professional nurses on staff observed Licensee's conduct on December 13, 2010 and all three believed her to be under the influence of some drug. Despite claiming a stomach virus, Licensee was not observed vomiting or running to the restroom. Licensee agreed to the drug test but asked to complete her charting first. Staff observed that Licensee could not stay on task and continued to put her head down. Licensee could not focus and had to be aroused to finish her work. Accordingly, the facility decided to proceed with the drug screen. Licensee then refused to submit to the drug test. Licensee was informed that she would be terminated if she refused. Licensee continued to refuse the drug test.
Censure 11/05/2013 to 11/06/2013

PROBATION

Morris, Cheri Lynn
Mountain Grove, MO
Registered Nurse 2005006900
Respondent was required to cause letters or statements of ongoing treatment evaluations from a mental health professional to be submitted to the Board by specified quarterly due dates. The Board did not receive an updated treatment evaluation form submitted on Respondent's behalf by either March 26, 2013 or June 26, 2013.
The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 26, 2013. However, the Board received a statement of unemployment on July 3, 2013.
Probation 10/08/2013 to 09/26/2015

PROBATION continued...

Beaty, Kathy E.
West Plains, MO
Licensed Practical Nurse 024063
On May 10, 2013, Licensee began working in Missouri. Licensee worked from May 10, 2013 through June 11, 2013. Licensee was working using her Texas nursing license while she applied to renew her Missouri nursing license. On June 11, 2013, Licensee reported that she discovered that her Texas nursing license was expired. Licensee practiced nursing in Missouri without a license from May 10, 2013 through June 11, 2013. On August 23, 2012, Licensee pled guilty to the class A misdemeanor of assault of a family member.
Probation 10/09/2013 to 10/09/2018

Gibson, Mary Elizabeth
Curryville, MO
Licensed Practical Nurse 2004025092
Respondent pled guilty to Possession of Up to 35 Grams Marijuana, a class A misdemeanor and Unlawful Use of Drug Paraphernalia, a class A misdemeanor.
Probation 10/08/2013 to 10/08/2018

Turner, Roger Allen
Olean, MO
Licensed Practical Nurse 2013042057
On August 13, 2007, Applicant pled guilty in the United States District Court for the Western District of Missouri for misappropriation of postal funds.
Probation 11/15/2013 to 11/15/2014

Lytton, Ashley Nicole
Holts Summit, MO
Registered Nurse 2006022276
The drug screen collected on January 24, 2011 was positive for Xanax and Percocet, and License admitted to diverting Xanax and Percocet.
Probation 10/24/2013 to 10/24/2016

Alexander, Sheri Lynn
Saint Charles, MO
Registered Nurse 2012001385
From January 24, 2013, until the filing of the Probation Violation Complaint on July 30, 2013, Respondent failed to call in to NTS on one (1) day. Respondent has alarms set to remind her to call NTS and also writes herself a note if she knows she is going to have a busy day. She did not realize that she had missed calling on one (1) day. As part of the terms of her probation, Respondent was required to completely abstain from the use or consumption of alcohol in any form. On June 24, 2013, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. When interviewed by the Medical Review Officer, Dr. Calvin Channell, Respondent stated that she had consumed Robitussin DM even though she knew it contained alcohol. Respondent admitted that she used poor judgment in consuming an entire bottle of Robitussin DM and knew it

PROBATION continued...

contained alcohol, but consumed it over the course of two (2) days because she was ill with bronchitis and wanted to sleep.
Probation 09/20/2013 to 01/11/2015

Menard, Aymilee Michelle
Eldon, MO
Registered Nurse 2005021682
From June 7, 2013 through August 19, 2013, Respondent failed to call in to NTS on one (1) day, to wit, July 16, 2013. As part of the terms of her disciplinary period and probation, Respondent was required to obey all federal, state, and local laws; and all rules and regulations governing the practice of nursing in this state. On June 26, 2013, Respondent pled guilty to Driving While Intoxicated, in the Circuit Court of Miller County as a result of her actions in which she drove while intoxicated, which occurred on September 20, 2012. Respondent also stipulated to this fact at the hearing. As part of the terms of her disciplinary period and probation, Respondent was required to completely abstain from the use or consumption of alcohol in any form regardless of whether treatment was recommended. At the hearing, Respondent testified and stipulated she last consumed alcohol on September 20, 2012. She further testified that since that date she has participated in a seven month "rehab" for alcohol abuse and has seen multiple counselors. At the hearing, Respondent testified and stipulated that she did not call into NTS as required on July 16, 2013.
Probation 10/08/2013 to 10/08/2018

Fulk, Corinna L.
Winona, MO
Registered Nurse 2003002686
Licensee was hired in approximately January, 2012 and terminated on November 5, 2012. On October 12, 2012, staff received a report from another staff member that Licensee's behavior while at work in wasting a narcotic the previous day was concerning. An inquiry into licensee's medication administration activity revealed that licensee was administering more Tramadol to her patients than her peers. Administrators requested that Licensee submit a sample for a for-cause drug test. Licensee provided a urine sample for screening. The sample that Licensee submitted tested positive for Tramadol and Valium. Licensee did not have and could not produce a prescription for Tramadol or Valium. Licensee admitted to the nurse supervisor that she "stockpiled" at home various prescriptions for herself and her family and admitted that she had in fact taken the Tramadol and the Valium from unlabeled containers.
Probation 11/08/2013 to 11/08/2018

Besand, Dawn M.
Hillsboro, MO
Registered Nurse 2000148452
In accordance with the terms of the Agreement, Respondent was required to contract with the Board approved third party

Probation continued on page 13

Probation continued from page 12

administrator, currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screening for alcohol and other drugs of abuse, the frequency and method of which shall be at the Board's discretion. Within twenty (20) working days of the effective date of this Agreement, Licensee was to complete the TPA's contract and submit the completed contract to the TPA. Respondent did not contract with NTS by July 11, 2013 as required by the Agreement. Respondent admitted in her testimony that she has not contracted with NTS for random drug and alcohol screenings.
Probation 09/24/2013 to 09/24/2016

Marrs, Jenniffer Renae
Mound City, KS
Registered Nurse 2011041705
Licensee was discovered sleeping several times while on duty at the home of client J, on January 16, 2013; January 22, 2013, and January 23, 2013. J's family members witnessed her sleeping and took three different pictures of her while she slept. Licensee falsified nursing notes by going to J's home at 0700 on January 21, 2013 and leaving at 0709 but then charting as if she had stayed from 0700 until 1600 and charted nursing notes at 0730, 0800, 0830, 0900, 1000, 1100, 1200, 1300, 1400, 1500, and 1600. Licensee also charted that she had a conversation with J's mother who was out of town at the time, an impossibility. Licensee falsified nursing notes on January 7, 2013, January 8, 2013, and January 9, 2013 by charting that she worked at J's home from 0700 to 1900 when in fact she only worked 0700 to 1600. Licensee falsified nursing notes on December 24, 2013 by charting that she worked at J's home from 0700 to 1700 when she only worked from 0700 to approximately 1200. Licensee made false entries of nursing notes at 1230, 1330, 1400, 1430, 1530, 1600 and 1700. Licensee falsified nursing notes on January 24, 2013 by charting that she worked at J's home from 0700 to 1800 when she had stopped working there at 1700. Licensee falsified nursing notes on January 28, 2013 by charting that she worked at J's home from 0700 to 1700 when she had stopped working there at 1600. On January 31, 2013, licensee spoke to a official by telephone and admitted that she had falsified the nursing notes of her working hours on December 24, 2012 and January 31, 2013.
Probation 10/09/2013 to 10/09/2016

Perkins, Erin LeAnn
Saint Charles, MO
Registered Nurse 2011016467
While employed at the hospital, on February 16, 2012, Licensee stole and diverted to herself by injecting into herself Propofol from the hospital's supply. Licensee was found by staff members lying on the floor with blood coming from a puncture site and a syringe containing Propofol and blood lying on the floor next to her. Licensee was treated at the hospital's emergency room and then suspended from employment. Licensee admitted to hospital officials and to the Board's investigator to injecting herself with Propofol. Licensee was allowed to enter into the Hospital's employee assistance program, and returned to work at the Hospital on April 30, 2012. Licensee, while at work on May 23, 2012 violated multiple policies and protocols of the Hospital, including: giving multiple medications to the wrong patient and then documenting that she gave them at 0900, even though the medications were not documented as "pulled" from the system until 1400; ordering blood on the wrong patient, delaying a CT to a critically ill patient, and documenting that the medications of Heparin and Protonix were administered to a patient, but never documenting them as being actually "pulled" from the system. Licensee was asked to submit to a for-cause drug screen by Hospital officials on May 25, 2012, and the sample licensee submitted tested positive for Propofol.
Probation 10/05/2013 to 10/05/2018

Rouse, Jennifer ONeal
Columbia, MO
Licensed Practical Nurse 2013035789
Applicant stated that in 2007, she was placed on the Employment Disqualification List (EDL) maintained by the Department of Health and Senior Services list for a term of five (5) years, and was removed from the list in January 2012. Applicant further explained that she was working at a long-term care facility as a certified nurses' aide on November 29, 2005 and was unable to get assistance from other staff members to transfer a resident to her bed after using the restroom. The resident's care plan directed staff to "keep hands on resident at all times during transfer." Applicant stated that she made the decision to transfer the resident to the bed by herself; however, she let go of the resident to move a chair and failed to utilize a gait belt when making the transfer and the resident fell as a result striking the back of her head. The resident sustained a head injury, was hospitalized, and subsequently passed away in the hospital eight (8) days later from an intracerebral hemorrhage. Additionally, on November 29, 2005, Applicant transferred another resident by herself although the resident's care plan required two (2) people to assist in transferring the resident.
Probation 09/25/2013 to 09/25/2015

Hamilton, James Lee
Kirksville, MO
Licensed Practical Nurse 2006026920
In accordance with the terms of the Agreement, Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of May 7, 2013. However, the Board did receive an employer evaluation on May 9, 2013. In accordance with the terms of the Agreement, Respondent was required to immediately provide a copy to his current employer as soon as he received it and also advise any potential employer of Respondent's probationary status and provide a copy of the entire agreement to any employer or potential employer. The Board received a letter from the Executive Director of Home Care, stating that Mr. Hamilton did not notify his employer of his disciplinary status with the Board of Nursing until May 9, 2013. Respondent testified that in regard to his probationary status, he informed his immediate supervisor "almost immediately", but stated he "did not remember the time I gave her the paperwork." He further testified that he did miss the meeting that was scheduled but did call the Board, but did not write down the date he called. He testified he spoke with either Lori Scheidt or Janet Wolken, but stated it was "50-50 either way" as to which one he spoke to. Respondent testified he gave a copy of the Agreement to his direct supervisor, but did not remember when that was. He testified that it was "a while before" May 9, 2013. Upon specific questioning by the Board, he testified that he "probably" did not give a copy of the settlement agreement to his employer within the first month of receiving it, but "definitely" did so within two months of receiving it. Witness KG testified that she did not know the exact date that she was notified by Respondent that he had entered into the settlement agreement, but she said the allegation in the letter that she was not notified until May 9, 2013, was not true. She further testified that the settlement agreement was turned in by Respondent to her a "week or two before" May 9, 2013.
Probation 09/24/2013 to 02/07/2016

Wagner, Kittie A.
Independence, MO
Registered Nurse 145103
Licensee was terminated on January 24, 2013. On January 8, 2013, Licensee was asked to submit to a urine drug screen test as a result of attendance issues; erratic behavior; and, a patient complaint that stated the patient had not received both of her Percocet that had been prescribed for pain. Licensee tested positive for Morphine. Licensee did not have a valid prescription for or a lawful reason to possess morphine. When questioned about the positive test for morphine, Licensee stated she took some of her mother's prescribed morphine for pain.
Probation 09/03/2013 to 09/03/2018

Dutcher, Melissa Renee
Saint Peters, MO
Licensed Practical Nurse 2009008891
On March 1, 2011, Licensee pled guilty to the class B misdemeanor of Driving While Intoxicated. On June 24, 2011, the Court revoked Licensee's probation and sentenced Licensee to 120 days in jail. On or about September 28, 2012, Licensee pled guilty to the class A misdemeanor of Driving While Intoxicated.
Probation 11/08/2013 to 11/08/2018

Shaw, Tonya Dione
Independence, MO
Registered Nurse 2009023492
On September 10, 2012, Licensee withdrew two (2) tablets of hydrocodone for patient 5913 at 1937. Licensee reported that she dropped those tablets, but did not chart the waste of the tablets until 2130. Licensee had those pills unsecured for two hours in violation of policy. On September 12, 2012, Licensee charted that she administered two (2) tablets of hydrocodone to patient 5913 at 0132. Records from the Pyxis show that Licensee did not withdraw those tablets for the patient until 0225. On September 12, 2012, Licensee charted that she administered two (2) tablets of hydrocodone to patient 8354 at 0048. Records from the Pyxis show that Licensee did not withdraw those tablets for the patient until 0227. On September 12, 2012, Licensee charted that she administered two (2) tablets of hydrocodone to patient 7613 at 0110. Records from the Pyxis show that Licensee did not withdraw those tablets for the patient until 0226. Patients 8354, 5913, and 7613 all reported receiving no medication through the night of September 12, 2012.
Probation 11/27/2013 to 11/27/2016

Probation continued on page 14

Probation continued from page 13

Schimmer, Mary Ashley
Grain Valley, MO
Registered Nurse 2009003868
From April 24, 2013, until the filing of the probation violation complaint on August 6, 2013, Respondent failed to call in to NTS on two (2) different days. Further, on June 10, 2013, Respondent failed to call NTS and this was a day that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 25, 2013. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the May 6, 2013 due date. Respondent requested to admit into evidence a letter from her psychiatrist and a letter from her therapist, which were accepted into evidence. The letter from the psychiatrist asked for "mitigating circumstances" be taken into account, that she not be disciplined for missing the chemical dependency evaluation due date due to her being in a car accident.
Probation 09/26/2013 to 09/26/2018

Strubinger, Rhonda S.
Cape Girardeau, MO
Licensed Practical Nurse 056592
On September 26, 2011, Licensee pled guilty to the Class A misdemeanor of theft/stealing with the value of the property less than $500.00. Licensee was given a suspended imposition of sentence and placed on two (2) years probation.
Probation 09/03/2013 to 09/03/2014

Steele, Rhonda K.
Kansas City, MO
Licensed Practical Nurse 045588
On July 4, 2008, Licensee removed 4 mg of morphine for Patient B at 2343. The morphine was not administer and was documented as wasted by Licensee at 0004. On July 5, 2008, Licensee performed a cancel/removed on the Benadryl drawer at 0046 under Patient B's name. There was no Benadryl ordered for the patient. Patient P was seen in the Emergency Department on July 11, 2008 and was discharged to go home at 2144. At 2152, after entering Patient P's name, Licensee performed a cancel/remove on the Benadryl drawer. Hospital security cameras taped Licensee entering the drawer, putting her hand toward her pocket and closing the drawer. Patient A had an order for morphine on July 2, 2008. Licensee removed 4 mg of morphine for the patient. At 0408 another nurse, VC, removed 10 mg of morphine for Patient A. VC documented the administration of 4 mg at 0408. The morphine Licensee withdrew was not administered and was documented as wasted at 0004. Licensee entered the

PROBATION continued...

Benadryl drawer of the Pyxis machine under the name of Patient A and removed vials of Benadryl. Patient A did not have an order for Benadryl. At 0900, a physician wrote an order for Fentanyl 50 mcg IV. Licensee removed 100 mcg of Fentanyl at 1903 and 1910. At 1916 and 1918, Licensee and another nurse wasted 150 mcg of Fentanyl. At 1921, a third nurse documented the administration of 50 mcg of Fentanyl.
Probation 10/09/2013 to 10/09/2015

Burke, Kelly Nicole
Sachse, TX
Registered Nurse 2004020662
On January 27, 2012, Respondent pled guilty to two (2) class C felony counts of stealing of a credit card. On January 27, 2012, Respondent pled guilty to the class C felony of stealing over $500 but less than $25,000 and to the class C felony of theft of a credit card. On January 27, 2012, Respondent pled guilty to the class C felony of burglary in the second degree. Respondent admitted that she became addicted to heroin and was involved with three other individuals in breaking into vehicles to steal various items, including credit cards and cash, among other items, in order to obtain heroin for personal consumption.
Probation 10/31/2013 to 10/31/2018

Kaufman, Laura J.
Saint Louis, MO
Registered Nurse 086016
Licensee pled guilty to the offense of driving while intoxicated on June 24, 2009. Licensee pled guilty to driving with excessive blood alcohol content and was convicted of this offense on December 28, 2010. Licensee was found guilty of the offense of Driving While Intoxicated on February 17, 2012 Licensee received treatment at the St. Anthony's Medical Center substance abuse treatment program from May 5, 2010 to June 30, 2010 and was diagnosed with alcohol dependence. She was discharged from the facility as non-compliant. She re-entered the program on August 8, 2010 and was discharged on August 13, 2010. Licensee entered the "Choices" substance abuse treatment program as ordered by the Circuit Court of St. Louis County, Municipal Division, on August 18, 2010 and completed the program on November 16, 2010. Licensee entered the Queen of Peace substance abuse treatment program on February 22, 2012 and completed the program on March 1, 2013. Licensee has not been participating in random drug or alcohol screenings. Licensee lists her date of sobriety and the date she last drank alcohol as May 4, 2012.
Probation 10/11/2013 to 10/11/2018

Trimble, Jamie Ranee
Cameron, MO
Registered Nurse 2013035608
On March 5, 2002, Applicant pled guilty to the class B misdemeanor of Driving While Intoxicated. On September 19, 2007, Applicant pled guilty to the class B misdemeanor of driving while intoxicated. On May 20, 2008, Applicant pled guilty to the class A misdemeanor of driving while intoxicated and endangering the welfare of a child.
Probation 09/23/2013 to 09/23/2016

Israel, Aaron Jeffrey
Ballwin, MO
Registered Nurse 2010028185
It was noted on July 12, 2011 that Licensee had 0% medication scanning scores and received his first counseling. Scanning the medications ensure the right medications are going to the right patient. Licensee was aware of the

PROBATION continued...

requirement of scanning medications, but stated it was "easier" to click on the medication in the patient record. On July 12, 2011, Licensee was placed on a Level 1 warning for failure to adhere to the Medication Administration Policy for failing to scan all patients and medications while administering the medications in the month of June 2011. The policy was discussed and reviewed with the Licensee. On July 29, 2011 a report was run to check the progress of scanning for Licensee. It was found that Licensee understood procedure and was able to demonstrate that he understood how to scan the medications but chose not to on particular days. Licensee continued to not follow the scanning policy and on August 4, 2011 was given a second counseling and placed on suspension pending investigation. On July 14, 15, 26, and 27 Licensee failed to follow the Medication Administration Policy again, bypassing all safety scanning features. A report from the pharmacy was run for the time period of May 1, 2011 through August 4, 2011 and it was determined that:

- Licensee had removed nineteen Xanax 0.25 mg; documented 17; two Xanax were not documented as administered or wasted
- Licensee had removed sixteen Xanax 0.5 mg; documented 15; one Xanax was not documented as administered or wasted
- Licensee had removed 111 Norco; documented 67; forty-four Norco were not documented as administered or wasted
- Licensee had removed forty-five Oxycodone IR 5 mg; documented 31; fourteen Oxycodone IR were not documented as administered or wasted
- Licensee had removed thirty-two Percocet; documented 24; eight Percocet were not documented as administered or wasted

Patient W.P. had an order for Hydrocodone one tablet QID, PRN. On the July 14-15, 2011 shift Licensee withdrew one Hydrocodone for W.P. at 2026, 2124, 2335, 0226 and 0401. Licensee did not document the administration or waste of these medications. On July 7, 2011 Licensee withdrew one Hydrocodone on patient D.C. at 0238 and 0433. These were withdrawn two hours apart. The 0433 dose was not documented as administered or wasted. On July 7, 2011 Licensee withdrew one Hydrocodone on patient D.C. at 1943 and 2116. These doses were not documented as administered or wasted. On July 12, 2011 Licensee withdrew one Hydrocodone on patient D.C. at 0059 and 0410. These doses were not documented as administered or wasted. On July 16, 2011 Licensee withdrew two Hydrocodone on patient J.M. at 2001 and 2049. Licensee documented the administration of one Hydrocodone. Three Hydrocodone were not documented as administered or wasted. On July 29, 2011 Licensee withdrew one Hydrocodone on patient D.A. at 2049 and 2204. These doses were withdrawn two and a half hours apart. Licensee did not document the administration or waste.
Probation 09/06/2013 to 09/06/2015

Marcum, Michael Leland
Columbus, GA
Registered Nurse 2002019966
Licensee's RN license was suspended by the North Dakota State Board of Nursing on November 9, 2010 and the North Dakota Board issued a Findings of Fact and Conclusions of Law in conjunction with the suspension of his nursing license. The Findings of Fact and Conclusions of Law included several findings in regard to licensee's behavior as a nurse, including that he tested positive for the illegal drug of cannabis while at work; manipulated IV drops of Fentanyl in patient's rooms; removed "sharps" containers from patients' rooms when they were not full; had inappropriate conversations with nursing staff of a sexual nature; allegedly removed narcotics from IV infusions, and demonstrated "panicky" behaviors of flushed skin and pacing, while at work.
Probation 11/19/2013 to 11/19/2016

McClure, Andrew Lindsey
Independence, MO
Registered Nurse 2003018585
On December 6, 2011, Licensee was caring for a patient along with a coworker, nurse JT. Licensee provided the patient with a tetanus shot. After giving the patient the shot, Licensee jabbed the used needle into nurse JT's shoulder. Licensee admitted to his supervisor that he had poked nurse JT with the used needle. Licensee said that he believed that the needle had been capped.
Probation 11/20/2013 to 11/20/2014

Probation continued on page 15

Probation continued from page 14

Rasnick, Sarah A.
Farmington, MO
Registered Nurse 2002015906
On August 10, 2012, Licensee fraudulently called in a prescription for herself for 60 tablets of Vicodin. On July 10, 2012, Licensee fraudulently called in a prescription for herself for 60 tablets of Vicodin. On August 1, 2012, Licensee fraudulently called in a prescription for herself for 120 Tramadol tablets. On April 4, 2012, Licensee fraudulently called in a prescription for herself for 120 tablets of Tramadol. On May 11, 2012, Licensee fraudulently called in a prescription for herself for 120 tablets of Tramadol.
Probation 10/23/2013 to 10/23/2018

Travers, Diane Marie
Ballwin, MO
Registered Nurse 2013033919
On November 14, 1990, Applicant was found guilty for stealing. On December 27, 1999, Applicant was arrested for stealing by switching the price tag on an item to a lower price. On April 24, 2000, Applicant pled guilty to stealing in the Municipal Court of Richmond Heights, Missouri. Applicant pled guilty to the class A misdemeanor of stealing on September 17, 2012, in the Circuit Court of St. Louis City, Missouri in case number 1122-CR04498.
Probation 09/11/2013 to 09/11/2016

Williams, Jerrica Joyce
Kansas City, MO
Licensed Practical Nurse 2006036039
Respondent failed to call in to NTS on eight (8) different days. On March 11, 2013, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading of 8.4. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the January 29, 2013, documentation due date. However, a chemical dependency evaluation was received by the Board on August 9, 2013. On April 5, 2013, Respondent reported to a lab and submitted a urine sample for random drug screening. That sample tested positive for the presence of oxazepam and temazepam.
Probation 10/08/2013 to 12/08/2018

Uptegrove, Jacinda Renee
Clinton, MO
Registered Nurse 2000146059
This Board and the Respondent entered into a Settlement Agreement (Agreement) effective June 5, 2013. In that Agreement, the parties stipulated that Respondent had violated the Nursing Practice Act and that her license was subject to discipline by the Board as a result of Respondent diverting Vicodin from her employer for her personal consumption. A review of Respondent's charting revealed that Respondent was removing more medication from the Pyxis than patients reported receiving. When confronted by

PROBATION continued...

administration, Licensee admitted to diverting Vicodin for her personal consumption.
Probation 09/20/2013 to 09/20/2018

Whitaker, Michelle M.
Warrenton, MO
Registered Nurse 116708
On November 10, 2011, Licensee pled guilty to the class C felony of Possession of Controlled Substance Except 35 Grams or Less of Marijuana. Licensee additionally pled guilty to the class A misdemeanor of possession of marijuana and the class A misdemeanor of unlawful use of drug paraphernalia.
Probation 10/23/2013 to 10/23/2016

VOLUNTARY SURRENDER

Simonton, Sherri Renee
Independence, MO
Licensed Practical Nurse 2009002063
On August 10, 2011 a Certified Nursing Assistant (CNA) was pulled over in a traffic stop and a bottle of promethazine with codeine belonging to a resident was found in her car. The Disposal or Return of Medication form for that bottle of promethazine with codeine was dated July 27, 2011 and it indicated that 70 ml of the medication was destroyed at the facility. Licensee signed the form, indicating she wasted or witnessed the waste of the medication. Licensee falsified a medical document by signing the disposal form when she in fact did not waste nor witness the waste of a controlled substance. In Licensee's written statement to the facility she admits to allowing a CNA access to a controlled substance. It was not in the CNA's job duties to destroy prescription or narcotic medications. On August 11, 2011 Licensee submitted to a drug screen that was positive for codeine and morphine. Licensee did not have a valid prescription for codeine or morphine. Licensee called her director of nursing on August 12, 2011 and admitted that she had consumed cough syrup with codeine that was not hers on August 11, 2011.
Voluntary Surrender 09/20/2013

Claerhout, Tammy K.
Independence, MO
Licensed Practical Nurse 056770
Licensee voluntarily surrendered her Missouri nursing license on 11-04-2013.
Voluntary Surrender 11/04/2013

Brummett, Patrick Norman
Belton, MO
Registered Nurse 2005021020
Licensee voluntarily surrendered his license on October 21, 2013.
Voluntary Surrender 10/21/2013

VOLUNTARY SURRENDER continued...

Reece, Patricha D.
New Franklin, MO
Licensed Practical Nurse 050104
Licensee held a license to practice licensed practical nursing, License No. L0054392, issued by the Oklahoma Board of Nursing until it was voluntarily surrendered on July 24, 2012. The voluntary surrender was based on an agreed stipulation made by licensee and the Oklahoma Board of Nursing in an Order that stated that on or about March 12, 2012, while Licensee was working as an PN in Colcord, OK, that she failed to transcribe a physician order for Lovenox which resulted in resident GM failing to receive the Lovenox for four days, resulting in resident GM having to be transferred to a hospital for evaluation. Licensee stipulated in the Order that her Oklahoma license was to be placed on voluntary surrender status for a period of two years which barred her from reapplying for her license until two years has passed from the date of the Order, with various reinstatement requirements required should she so apply. The Stipulation, Settlement, and Order was approved in full on July 24, 2012.
Voluntary Surrender 11/05/2013

Nolen, Mark Allen
Kennett, MO
Licensed Practical Nurse 2003019170
On November 3, 2012, licensee was in a motor vehicle accident and was initially charged with driving while under the influence of drugs. Licensee underwent a urine test as a result of the arrest, and the test was positive for Zolpidem, Paroxetine, Citalopram, Desmethylcitalopram, Promethazine and Diphenhydramine. Licensee had previously been warned by his physician not to take the Paroxetine and the Citalopram together at the same time. On November 8, 2012, a physician for OG contacted staff and requested that licensee no longer be allowed to see any of her patients. She said this because she had suspected licensee of stealing and diverting to himself OG's Ativan while at OG's home. An interview with OG later confirmed that OG had in fact witnessed licensee taking her Ativan when refilling her medication tray and licensee informed OG that "the pharmacy had shorted her on pills again. Licensee also on November 8, 2012, requested an increase in OG's Ativan from .5mg to 1 mg. Licensee did not tell OG he was doing this. OG's physician then notified OG's pharmacy she did not want licensee to ever pick up any medications from the pharmacy for any of her patients again. Licensee illegally and unlawfully took the Ativan to divert controlled substances to himself; and was dishonest and committed misrepresentation by requesting an increase in OG's Ativan without authority, and in doing so was practicing outside the scope of his nursing license.
Voluntary Surrender 10/21/2013

Voluntary Surrender continued on page 16

Voluntary Surrender continued from page 15

Levos, Tammy Renell
Lees Summit, MO
Licensed Practical Nurse 2000144417
Pharmacy reported that an initial prescription for hydrocodone for Licensee had been called in on November 3, 2010, prescribed by doctor SA. Pharmacy records indicate that the prescription had been refilled twenty-seven (27) times. Doctor SA did not authorize the prescription of hydrocodone for Licensee. On August 21, 2012, Licensee was confronted by doctor SA about the prescription and Licensee admitted to falsifying the prescription.
Voluntary Surrender 10/23/2013

Hadfield, Carla Pauline
Saint Louis,MO
Registered Nurse 2008021438
Count I
On or about November 17, 2010, Licensee resigned in lieu of an impending termination. The Facility had been conducting a controlled substance audit based on apparent discrepancies of Licensee's wasting of Fentanyl, a controlled substance. The audit revealed that in many cases there was no waste of the Fentanyl as required by hospital policy and state and federal drug laws. The Facility requested that Licensee submit to a for cause drug test which Licensee agreed to do. Licensee's drug test was positive for benzodiazepines, controlled substances. Licensee did not document having a prescription for benzodiazepines. During an initial interview, Licensee admitted to the diversion of Fentanyl. The Facility did not ask Licensee if she diverted any other drugs. Licensee also admitted to refilling patient controlled analgesic containers with tap water and placing them back in the Omnicell for storage. Licensee resigned on November 17, 2010 as a result of the investigation.
Count II
January 23, 2011, while on duty, Licensee withdrew narcotics for patients not under her care. A total diversion report for January 23, 2011, reported that Licensee withdrew and diverted: 5 Dilaudid 1mg/ml carpujects; six Morphine 2 mg/ml carpujects; 8 Hydrocodone 5/325 mg tablets and 5 Oxycodone 5/325 mg tablets. The Facility identified the alleged diversion and improper charting and Licensee admitted to a relapse and diversion of narcotics. The Facility terminated Licensee as a result.
Voluntary Surrender 9/26/2013

REVOKED

Johnston, Stacy Nicole
Florissant, MO
Licensed Practical Nurse 2007016299
From February 9, 2013 through July 29, 2013, Respondent failed to call in to NTS on twenty-four (24) days. Further, on June 13, 2013 and July 11, 2013, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, of the twenty-four (24) calls mentioned above, seven (7) of them, on March 5, 2013; March 28, 2013; April 10, 2013; April 19, 2013; May 9, 2013; May 24, 2013; and July 5, 2013, Respondent failed to call NTS; however, those were days that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on March 5, 2013; March 28, 2013; April 10, 2013; April 19, 2013; May 9, 2013; May 24, 2013; and July 5, 2013.
Revoked 09/10/2013

McFadden, Holly A.
Springfield, MO
Registered Nurse 2007014364
On October 17, 2010, around 8:00 a.m., the DON, received a call that Respondent was acting "funny" and seemed spaced out. On October 17, 2010, at 8:30 a.m., The DON arrived at the hospital to observe Respondent. DON found Respondent sitting in front of the computer with her head down and eyes closed. DON took Respondent to her office and asked her if she had ingested any medications and/or drugs. Respondent informed DON that she ingested her mother's Xanax and Percocet due to a migraine. Respondent later admitted that two days prior she had used Methamphetamine. On October 17, 2010, Respondent was asked to submit to a drug test based on her reported actions and admissions. Respondent voluntarily took a drug screen test which showed positive for Methamphetamine and Propoxyphene. Respondent stated that she had been using Methamphetamine for about a year. The DON visited all Respondent's patients she cared for from 7:00 p.m. on October 16, 2010, to 7:00 a.m. on October 17, 2010. One of Respondent's patients reported that Respondent came to work at 7:00 p.m. on October 16, 2010, but he did not see her until 10:00 p.m. The patient stated that Respondent was acting weird, giggly, and appeared to be high on something. Respondent connected the patient to the wrong IV tubing and he had to tell her to clear the tubing as it was full of air. Respondent asked the patient what his blood pressure was and based on his response she put that into the system instead of actually taking the patient's blood pressure herself. Another patient (S), indicated that at 3:00 a.m. on October 17, 2010 she called Respondent for pain medication and S's wound vacuum was beeping. Respondent never responded to S's 3:00 a.m. call. At 6:30 a.m. on October 17, 2010, Respondent reported to patient S's room and wanted to check her blood sugar and give S her IV medication. S stated she told Respondent that she had the wrong patient because she did not need blood sugar check or receive an IV medication. On October 16, 2010, and October 17, 2010, Respondent was under the influence of controlled substances while on duty. On October 16, 2010, and October 17, 2010, Respondent consumed Methamphetamine and Propoxyphene to such a degree it impaired her ability to perform the work of a registered professional nurse. On October 16, 2010, and October 17, 2010, Respondent was impaired to such an extent that she was unable to function or perform her duties as a nurse; therefore, jeopardizing the health, safety, and welfare of herself and her patients.
Revoked 09/11/2013

Harmon, Kelley A.
Kansas City, MO
Licensed Practical Nurse 053395
Licensee failed to provide a sample for testing on one (1) occasion, provided two (2) samples which tested positive for alcohol metabolites, admitted to consuming alcohol, and failed to submit a chemical dependency evaluation by the due date.
Revoked 09/12/2013

Lawrence, Aida G.
Kansas City, MO
Registered Nurse 1999140166
On December 2, 2010, Respondent was on duty at the Medical Center. Her shift ended at 5:00 p.m., but she remained on call. At approximately 6:15 p.m., while on call, housekeeping personnel discovered Respondent on the floor of a bathroom at the Medical Center. Respondent was unconscious and had a tourniquet around her right arm and a 20cc syringe stuck in her arm. Further, there was blood on her hand, her clothing, the wall, and the floor. The syringe contained between 0.5cc to 1cc of pink colored propofol. Propofol is a milky white substance that appears pink when combined with blood. Respondent claimed she simply passed out due to diarrhea. There was no evidence of diarrhea in the bathroom. A urine screen revealed Respondent was positive for lidocaine and propofol.
Revoked 09/12/2013

Neal, Tara Rae
New Madrid, MO
Licensed Practical Nurse 2008029212
On July 20, 2011, Respondent was asked to submit to a drug screen per policy, as she appeared sluggish and had a flat affect. Respondent refused to submit to a drug screen and left the facility. Respondent left without passing report on her patients, thus abandoning them.
Revoked 09/11/2013

Bowling, Andrea R.
Elkland, MO
Licensed Practical Nurse 2000170832
Licensee failed to meet with the Board's representative as required by the Agreement and failed to submit an employer evaluation or statement of unemployment by the documentation due date.
Revoked 09/12/2013

Revocation continued on page 17

Revocation continued from page 16

Henke, Jamie L.
Hazelwood, MO
Registered Nurse 110458
Respondent was required to contract with the third party administrator, currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screening for alcohol and other drugs of abuse. Respondent did not contract with the TPA as required. Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting. Respondent was required to complete a chemical dependency evaluation required by the Board. Respondent did not complete the chemical dependency evaluation and the Board has not received the results of any chemical dependency evaluation.
Revoked 09/12/2013

Russell, Brian J.
Joplin, MO
Registered Nurse 133312
In accordance with the terms of the Order, Respondent was required to contract with the Board approved third-party administrator, currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screening for alcohol and other drugs of abuse within twenty (20) working days of the effective date of the Order. Respondent was required to complete the contract by July 25, 2013. Respondent did not contract with NTS. Respondent testified that he is no longer able to work as a nurse and has no intentions of contracting with NTS or submitting to drug and alcohol screenings.
Revoked 09/12/2013

Bond, Mary Jane
Saint Louis, MO
Licensed Practical Nurse 033490
On February 4, 2011, at 11:00 p.m., T.R., CNA, reported to Respondent that patient, E.S., was breathing heavy and sweating. On February 4, 2011, at or around 11:00 p.m., Respondent did not check patient, E.S.'s, temperature or do an assessment. On February 5, 2011, at 1:00 a.m., T.R., CNA, reported to Respondent that patient, E.S., did not look good and was panting. Respondent was aware that patient, E.S., had a temperature over 104 degrees and his blood sugar was 404. Respondent indicated that at 1:00 a.m. on February 5, 2011, she administered Tylenol to patient, E.S. Respondent did not do an assessment of the patient at the time she administered the Tylenol nor did she notify the patient's physician of his change in condition. On February 5, 2011, at 3:00 a.m., T.R., CNA, reported to Respondent that patient, E.S.'s, respirations were rapid. Respondent stated she documented the administration of Lantus to patient, E.S. at 3:00 a.m. on February 5, 2011, but did not recall why, as the patient's chart shows the Lantus order was to be given at 7:00 a.m. daily. On February 5, 2011, at 3:00 a.m., Respondent made her first entry regarding patient, E.S. On February 5, 2011, at 3:00 a.m., Respondent indicated in patient, E.S.'s, chart that "Tylenol was given, temperature was 104.1, blood sugar 404, Lantus given (no dose documented), diaphoretic, beads of sweat on forehead, will continue to monitor." On February 5, 2011, at 5:00 a.m., Respondent indicated that she checked patient, E.S, who had a temperature of 102 and blood sugar of 404. She did not document the results in her nursing notes. Respondent found patient, E.S.'s, legs were turning blue but she did not start any oxygen. On February 5, 2011, at 6:30 a.m., T.R., CNA, checked on patient, E.S., before leaving and found that he was sweating profusely and his respirations were hard and rapid. The day shift nurse asked Respondent how long the patient had been in his current condition and why she had not called the patient's physician to get an order to have the patient sent to the hospital. After being questioned by the day shift nurse, Respondent contacted the Director of Nursing (DON) around 7:00 a.m. on February 5, 2011, to report the patient's change in condition. The DON instructed Respondent to send the patient to the hospital immediately and to contact the patient's physician. Respondent failed to send the patient to the hospital immediately, but instead waited for a return call from the patient's physician. On February 5, 2011, Respondent called for the Emergency Medical Technician (EMT) to have the patient transported to the hospital instead of 911.
Revoked 09/12/2013

Henderson, Lisa M.
Springfield, MO
Licensed Practical Nurse 2004018180
On November 17, 2010, Respondent pled guilty to the class B misdemeanor of driving while intoxicated in the Circuit Court of Christian County, Missouri. On January 12, 2011 Respondent completed a reasonable cause drug screen. The test was positive for amphetamine, methamphetamine, and marijuana, controlled substances for which Respondent did not have a prescription, or a lawful reason to possess.
Revoked 09/20/2013

Voss, Elizabeth Maria
Iberia, MO
Registered Nurse 2010010363
On November 28, 2012, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent's EtG level was 20,801 nanograms per milliliter (ng/ml) and her EtS level was 6,566 ng/ml. On December 17, 2012, Respondent again reported to a collection site to provide a sample and the sample again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent's EtG level was 1,209 ng/ml and her EtS level was 668 ng/ml. In addition, Respondent's creatinine level on December 17, 2012, was 9.8, which is suspicious for a diluted sample. On January 10, 2013, Respondent again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol, when she reported to a collection site to provide a sample. Respondent's EtG level was 840 ng/ml and her EtS level was 385 ng/ml. On Wednesday, February 13, 2013, Respondent reported to a collection site to provide the required sample, which was once again positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent's EtG level was 11,299 ng/ml and her EtS level was 4,530 ng/ml. On March 14, 2013, Respondent's creatinine level was 14.2, which is suspicious for a diluted sample. On Friday, March 22, 2013, Respondent reported to a collection site to provide the required blood sample, which was positive for Phosphatidyl ethanol (PEth), a metabolite of alcohol. The PEth level was 321 ng/ml. On Friday, April 5, 2013, Respondent again reported to a collection site to provide the required sample, which again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent's EtG level was 1,039 ng/ml and her EtS level was 462 ng/ml. On Thursday, June 13, 2013, Respondent reported to a collection site to provide the required sample, which again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Additionally, her creatinine level was 14.3 on that date. Respondent's EtG level was 9,134 ng/ml and her EtS level was 3,562 ng/ml. On July 12, 2013, Respondent reported to a collection site to provide the required sample, which tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent's EtG level was 11,588 ng/ml and her EtS level was 3,508 ng/ml. Since the beginning of Respondent's probation, Respondent has failed to call in to NTS on four (4) occasions, to-wit: March 17, 2013; May 13, 2013; May 19, 2013; and, June 29, 2013. The Board did not receive an employer evaluation by the documentation due date of July 17, 2013. The Board did not receive an evaluation update or letter of final evaluation/ summary by the documentation due date of July 17, 2013. The cutoff for EtG is 500 nanograms per milliliter. The cutoff for EtS is 100 nanograms per milliliter. The standard of care for monitoring professionals for alcohol abstinence is urine EtG/EtS testing followed with PEth tests after positive EtG results. Hand sanitizer exposure would only be significant if the EtG level was below 2,000 ng/ml, which is the highest level anyone has ever been able to produce using hand sanitizer and then measuring urine EtG. The highest level for EtS after hand sanitizer use was 75 ng/ml. Multiple positive urine EtG/EtS tests indicate ongoing ingestion of ethanol. Blood spot PEth test stands for phosphatidylethanol which is another metabolite of ethanol that is more reliable in terms of assessing how much someone may be drinking because the levels correlate more closely with the amount of alcohol consumed. PEth can detect binge drinking or regular, constant drinking over a period of time. The cutoff for PEth is 20 nanograms per milliliter. A PEth level of 321 ng/ml indicates ongoing, regular drinking that correlates to three standard drinks per day during the two to three-week time period prior to the test. It is more likely than not that she is ingesting ethanol on a regular basis. Respondent testified that she drank alcohol on one occasion during her probation. She stated that when she found out her case was going to be going in front of the Board she drank alcohol on one day at the beginning of March when she consumed six (6) beers. Respondent stated that she did not drink on any other occasion.
Revoked 09/13/2013

Knehans, Robin Rachalle
Saint Louis, MO
Licensed Practical Nurse 2012002713
On April 12, 2013, Respondent reported to a lab and submitted the required sample which showed a low

Revocation continued on page 18

Revocation continued from page 17

creatinine reading, which was 12.1. A creatinine level below 20 is a diluted sample and deemed a failed test. On May 4, 2013, Respondent reported to a collection site to provide a PEth Blood Spot sample and the sample tested positive for phosphatidyl ethanol (PEth), a metabolite of alcohol. Respondent was contacted by Dr. Greg Elam, the Medical Review Officer of NTS. Respondent informed him that she could not talk and would call him back. Respondent never returned the call to Dr. Elam. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of July 26, 2013. Respondent was required to obtain continuing education hours. The Board did not receive proof of completion of any of the required hours. On June 24, 2013, July 9, 2013, and July 29, 2013, Respondent was required to report to a collection site and submit a urine sample for screening, but did not appear on any of those three days.
Revoked 09/10/2013

Rhodes, Sandra L.
Blue Springs, MO
Licensed Practical Nurse 2009010471
In accordance with the terms of the Order, Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 25, 2013. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by June 25, 2013. The Board did not receive proof of completion of any of the required hours.
Revoked 09/11/2013

Branson, Carole L.
Overland Park, KS
Registered Nurse 093520
The Board received information that the Kansas State Board of Nursing had disciplined the Kansas nursing license of Respondent. The facts leading to the Kansas Board to discipline Respondent's Kansas nursing license are as follows:

a. On or about April 20, 2009, Respondent was hospitalized with a diagnosis of poisoning by benzodiazepine-based tranquilizers.
b. Respondent told the triage nurse that she "just needed to sleep" and took Lorazepam she had taken from the hospice center where she worked.
c. At the time, Respondent was employed in a skilled nursing unit.
d. Nine different prescription medications belonging to six current or former residents were found in Respondent's residence.
e. As a result of this incident, the Kansas Board of Nursing referred Respondent to the Kansas Nurses Assistance Program (KNAP).
f. On or about November 17, 2009, KNAP closed Respondent's KNAP case due to noncompliance on the part of Respondent. KNAP reported that Respondent failed to complete a drug and alcohol assessment and return a signed release of information forms.

Revoked 09/12/2013

Woods, Melissa Kay
Farmington, MO
Registered Nurse 2012034842
During Respondent's probation in accordance with the terms of the Amended Order, Respondent failed to call in to NTS on thirty-eight different (38) days. Respondent additionally failed to report to a collection site when selected for testing on June 25, 2013; July 9, 2013 and July 30, 2013. On May 28, 2013, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of Amphetamines and Methamphetamine. In addition, on June 7, 2013, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of Cocaine, Amphetamines and Methamphetamine. Respondent testified that she "was guilty" and testified that she used cocaine "maybe a week or two before" May 28, 2013. She further testified at the hearing before the Board on September 5, 2013 that she last used methamphetamines and amphetamines "about a week ago, maybe, a week ago." Respondent further testified that she had stopped calling into NTS because she "pretty much had given up." Upon specific questioning by the Board, Respondent testified that she hadn't been "using" in about a week, but prior to that had been "using" "maybe every other day."
Revoked 09/12/2013

Roux, Monica A.
Edina, MO
Licensed Practical Nurse 057529
On March 3, 2011, Respondent appeared for duty exhibiting unusual behavior. Respondent was observed to be irritable,

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shaking, trembling, aggressive towards other staff, speaking loudly, speaking fast, fidgety, and with red eyes. Also on March 3, 2011, a resident under Respondent's care fell, and Respondent failed to follow the protocol for this emergency. Based on the aforementioned observances and behaviors exhibited by Respondent, she was asked to submit to a urine drug screen by the Nursing Home. The urine drug screen revealed that Respondent possessed and tested positive for Lorazepam, Hydrocodone and Marijuana.
Revoked 09/12/2013

Roland, Sandra L.
Kansas City, KS
Registered Nurse 122217
On March 4, 2013, the Board entered an "Order of the State Board of Nursing Regarding Issuance of a Probated License to Sandra Roland" (Order). Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not contact the Board after receiving this Order, nor did she attempt to reschedule the meeting or to inquire what she needed to do. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 4, 2013.
Revoked 09/12/2013

Lahm, Candice Elizabeth
Kansas City, MO
Registered Nurse 2010034426
Licensee failed to contract with NTS within twenty (20) working days of the effective date of the Agreement, failed to contact NTS on fifty (50) days, failed to provide samples for testing on three (3) occasions, failed to submit a chemical dependency evaluation by the due date, failed to submit an employer evaluation or statement of unemployment by the due date, failed to submit proof of completion of continuing education courses, and failed to renew her nursing license.
Revoked 09/11/2013

Shepard, Kenneth Edward
Bixby, OK
Registered Nurse 2007035074
The Oklahoma State Board of Nursing disciplined Respondent's Oklahoma nursing license on September 23, 2009, pursuant to a consent order, signed and agreed to by Respondent, agreeing that his license in Oklahoma was subject to discipline, in part, as a result of:
On or about May 28, 2008, the District Attorney for Tulsa County, Oklahoma, filed information in the District Court of Tulsa County, Oklahoma, Case No. CF-2008-2439, charging Respondent with: Count I: Lewd molestation, a felony; and Count II: Obscene Electronic Communication, a misdemeanor by unlawfully, feloniously, knowingly, and intentionally making electronic and/or computer generated lewd or indecent proposals to a child under sixteen years of age by communicating with a minor child's mother, on the telephone, via text message and instant messenger, that he wanted to have sexual intercourse with minor child and wanted minor child to perform sexual conduct on him. The District Court of Tulsa County, Oklahoma entered its sentence and judgment on July 25, 2008, finding that Respondent pled guilty to two counts of obscene electronic communication.
Revoked 10/08/2013

Hartmann, Tammy Ann
Eolia, MO
Registered Nurse 2003005350
Respondent had a sexual relationship with a resident.
Revoked 09/26/2013

Schlette, Tamara Lynn
Saint Charles, MO
Licensed Practical Nurse 2000152456
Respondent has failed to call in to NTS on one (1) day. In addition, on two separate occasions, June 10, 2013, and February 12, 2013, Respondent reported to lab and submitted the required sample which showed low creatinine readings. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of May 13, 2013. The Board did not receive proof of any completed hours of required continuing education hours by the documentation due date. On July 24, 2013, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of clonazepam, oxycodone, and oxymorphone. On May 9, 2013, Respondent submitted a sample that tested positive for clonazepam, oxycodone, and oxymorphone.
Revoked 09/24/2013

REVOCATION continued...

Ward, Clyde Edward, II
Hannibal, MO
Registered Nurse 2010035656
Respondent was required to contract with the third-party administrator, currently National Toxicology Specialists, Inc. (NTS), and participate in random drug and alcohol screenings. During Respondent's probation, Respondent failed to call in to NTS on one (1) day, July 8, 2013. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of April 24, 2013, and July 24, 2013. The Board did not receive an update of treatment evaluation from a chemical dependency professional submitted on Respondent's behalf by the documentation due dates of April 24, 2013, and July 24, 2013. The Board did not receive proof of support group attendance by the April 24, 2013, and the July 24, 2013, documentation due dates. The terms of the Agreement additionally required Respondent to renew his nursing license within five (5) working days of its expiration and not allow his license to lapse. Respondent's registered professional nursing license lapsed on April 30, 2013, and was not renewed until July 17, 2013.
Revoked 09/12/2013

Bollman, Stacie Dawn
Madison, MO
Licensed Practical Nurse 2008027760
On February 16, 2012, Respondent forced a resident to walk when the resident did not want to, causing the resident to fall several times. Because of her actions, Respondent's name was placed on the Department of Health and Senior Services Employee Disqualification list.
Revoked 09/10/2013

Sylla, Samantha Jean Marie
Saint Ann, MO
Licensed Practical Nurse 2011029814
During Respondent's probation period, Respondent has failed to call in to NTS on three (3) days. Further, on June 5, 2013, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent appeared for the drug screen and stated that she had brought someone else's urine to use in the drug screen after being informed that her urine screen was required to be observed. Respondent further stated that she took a tramadol the night before the test for which she did not have a prescription for in her name. Respondent was given the option of doing the test with Respondent's own urine, or not do the test at all. Respondent left the office without providing a sample. Respondent failed to assure that lab personnel observe all urine specimen collections. In accordance with the recommendations of the chemical dependency professional, Respondent was required to work with a sponsor and submit evidence of weekly attendance at Narcotics Anonymous meetings. The Board received proof of attendance at Narcotics Anonymous meetings by the quarterly due dates. On each of the support group meeting report forms Respondent stated that she was not required to have a sponsor.
Revoked 09/24/2013

Social Networking and Nurses

Crystal Tillman Harris, DNP, RN, CPNP
July 2013

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Two highlights for the article:

The use of social networking can have numerous benefits but also unintended consequences for an individual nurse's career. and

Remember that standards of professionalism are the same online as in any other circumstance.

The use of social media, including Facebook, Twitter, LinkedIn, YouTube, blogs, chat rooms, MySpace and other similar sites are increasing exponentially. A 2010 Pew report stated that among adults, 73% use Facebook, and 14% use LinkedIn (Pew Report, 2010). The use of social media will continue to rise and is a common daily occurrence for most of us.

Nurses have an added responsibility of ethical use related to personal use of social networking. Once again this year, nurses were ranked highest on honesty and ethical standards according to the Gallup poll, as being the most trusted profession in the United States (Jones, 2011). Nurses have held the number one spot every year since 1999, with the exception of 2001 when firefighters topped the list following the September 11 attacks. As nurses, it is important to uphold the public's trust and respect in all areas of our lives, including the use of social networking. Therefore, as the most trusted healthcare professionals, nurses should not only understand the use of these technologies, but nurses should also consider when or where to use these technologies.

Benefits of Social Networking

It is wonderful to live in an age of social networking and see the benefits provided to nurses. As nurses, we educate our patients and can provide appropriate websites for patient and family education. Many nurses use it as a means of professional networking and communication with colleagues. Networking can also disseminate research and evidence-based practice findings to colleagues. Smart phones and tablets have entered the health care arena and allow easy access of vital information that can ensure effective care of the patient. The benefits of social networking are numerous, and will increase in the future.

Concerns of Social Networking

With the increase in technology, also come some concerns for the profession. Inappropriate sharing of personal or work information that reflects poorly on the nurse and professionalism in nursing is a concern for all of us. Many times breaches of patient confidentiality can occur, either intentionally or inadvertently. Examples include description of a patient with enough detail for identification, posting videos or pictures of patients, and referring to the patient in a demeaning manner (ANA, 2011). This can lead to a breach of patient confidentiality and privacy and damage to a nurse's career.

Also of concern is the ability of the nurse to become distracted while using smart phones. Such distractions have the potential to be catastrophic. There are appropriate uses of technology at work during patient care…and checking one's Facebook status is not one of them!

Students have been expelled from nursing school for posting online photos of themselves with a placenta and nurses have been fired for discussing patient cases on Facebook. In the *Brynes vs. Johnson County Community College* litigation, a nursing student posted a photo of herself with a placenta on her personal Facebook page. The photo went viral within hours; the student was expelled one day later and was told that she could re-apply to enter the program the following year. The patient issue was that in the photo you could see the student's ID badge and the school's patch on her uniform. By right-clicking on the photo the embedded date of the photo is retrievable. Since few babies were delivered in that hospital that day, it was easy to "track" and connect the placenta to the patient. "The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral" (Hader, 2010).

Principles for Social Networking

The National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) have mutually endorsed each organization's guidelines for upholding professional boundaries in a social networking environment and have created a joint webinar on *Guidelines for Social Media* (ANA and NCSBN, 2011). The NCSBN *White paper: A nurse's guide to the use of social media* lists actions nurses can take to minimize risk and provides scenarios of unprofessional behavior based on actual events reported to Boards of Nursing (NCSBN, 2011).

The ANA publication, *Principles for Social Networking and the Nurse: Guidance for the Registered Nurse*, is based on the ANA foundational documents on ethics and standards of practice (ANA, 2011). A Social Networking Principles Toolkit consisting of a fact sheet, tip-card, and poster is available at no cost on the ANA website: http://nursingworld.org/socialnetworkingtoolkit

The American Nurses' Association (ANA) has developed a guideline for use of social media by nurses that includes principles for social networking that can lead to appropriate use of the technology (ANA, 2011). Simply removing a name or face does not necessarily protect the patient's identification. The principles are:

- Nurses must not transmit or place online individually identifiable patient information.
- Nurses must observe ethically prescribed professional patient-nurse boundaries.
- Nurses should understand that patients, colleagues, institutions, and employers may view postings.
- Nurses should take advantage of privacy settings and seek to separate personal and professional information online.

Nurses should bring content that could harm a patient's privacy, rights, or welfare to the attention of appropriate authorities. Nurses should participate in developing institutional policies governing online conduct.

The Health Insurance Portability and Accountability Act (HIPAA) protection includes information that can reasonably be used to identify the patient.

HIPAA's Dos and Don'ts of Social Networking:

- Do make a distinction between your personal life and professional life online.
- Do use social media for educational and professional purposes.
- Do be mindful of HIPAA.
- Do set your privacy settings as high as possible.
- Don't be lulled by false security.
- Don't discuss your patients or your colleagues.

The Code of Ethics for Nurses provides a framework for nurses in ethical decision-making and can provide guidance in the use of social media (ANA, 2001). The Code of Ethics for Nurses reminds us of our primary commitment to patients, to practice with compassion and respect for all individuals, and the requirement to disseminate knowledge (ANA, 2001). According to the ANA:

The patient's well-being could be jeopardized and the fundamental trust between patient and nurse be destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written, or electronic.

Consequences for Inappropriate Use of Social Networking

There are consequences to inappropriate use of social media. The potential consequences vary according to the specific breach of trust. The incident may be reportable to the Board of Nursing. The Board may investigate the nurse after a report of inappropriate use of social media on the grounds of (NCSBN, 2011):

- Unprofessional conduct
- Unethical conduct
- Moral turpitude (a evil quality of behaving)
- Management of patient records
- Revealing a privileged communication: and
- Breach of confidentiality

Social Networking and Nurses continued on page 21

Social Networking and Nurses continued from page 20

If the Board finds the allegations to be true, the nurse can face disciplinary action ranging from a reprimand or sanctions to temporary loss of license. Thirty-three state BONs reported complaints last year against nurses who violated patient privacy using social media (NCSBN, 2011). In many cases, the nurse inadvertently breached confidentiality.

There may be other consequences also. The nurse may face complaints that a state or federal law to protect patient confidentiality was breached. This violation can result in civil or criminal charges. There is also the possibility the nurse could face a lawsuit for personal damages including defamation or invasion of privacy. If employment rules were broken, the nurse may face suspension or termination at work.

The line between speech protected by labor laws and the First Amendment and the ability of an employer to impose expectations on employees outside of work is still being determined (National Labor Relations Board, 2011). Nonetheless, inappropriate comments can be detrimental to a cohesive health care delivery team and may result in sanctions against the nurse (Cronquist and Spector, 2011).

Policies

Organizations are finding the need to develop policies and professional guidelines to aid nurses in negotiating responsibly and professionally the use of social networking. This is beginning to happen in some medical institutions but needs more widespread attention in order to avoid legal and ethical problems.

Managers need to be aware that, although sending a friend request to an employee might seem rather fun and friendly, it could have unintended consequences. Even if the manager is comfortable initiating the request, the employee may not feel the same way, creating a potentially negative undertone to their working relationship. It may lead to potential claims of fraternization, harassment, or stalking.

Inappropriate social networking should also be included in nursing education program curriculums. Discussions of professional conduct and ethical behavior in the health care workplace and clinical settings are necessary. The importance of social networking must be a priority with new students during orientation, and the potential pitfalls social media may create for nurses.

Most health care employers expect that the employee will follow the same behaviors online as they would in face-to-face contact. Be sure to know the policies of your employer or academic institution. Many institutions now have policies such as:

- Do not "friend" patients
- Do not accept "friend requests" from patients or their family members
- Never share any patient information via Facebook or other social media
- Never post pictures of patients or pose with patients for pictures.
- Never give medical advice via social media.

Summary

Our online conversation should reflect the same professionalism that is expected when working with the public. If you are about to post an item that you know would be embarrassing if seen by a colleague, employer, patient, or family member, then do not post it. It is essential to maintain professional integrity when incorporating networking, even when doing so only in your personal life.

Remember once you post something, there is a digital footprint forever. Just because you delete a post, photo or video, does not mean it is destroyed. Data can be retrievable from law enforcement or technology experts.

The golden rule in social networking is this: assume that there is no privacy. Pretend that what you are writing is appearing on a permanent billboard. If you would not want it to be printed for all to see, then think twice before posting to a social media site.

Examples of Inappropriate Posts from Ethical Reasoning and Online Social Media:

My patient was the cutest little 70-year-old lady. And I found out she lives in my neighborhood. Awesome…a new friend.

So far, my clinical sucks…when will I start doing the fun stuff?

First day of orientation, and I feel completely overwhelmed! I seriously don't know what I'm doing yet. I feel sorry if you were my patient today…but I will get better.

The new staffing policy here is awful…who thought it was OK to have each nurse have 6 patients. Looks like our NAs will have to do a lot more!

Friday afternoon….so glad the weekend is here. Time to get drunk. I need a vacation from responsibility.

What's up everyone? I'm on a break at clinical and had some time to post. Anybody out there have a minute to catch up?

I'm going to make sure that I have a living will. I just don't understand why the patient I cared for today wants "everything done" to hang on.

My supervisor was bugging me today to join ANA. Why would I need to do that?

(Englund et al., 2012)

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Schedule Of Board Meeting Dates Through 2015

March 5-7, 2014
June 11-13, 2014
September 3-5, 2014
November 19-21, 2014
March 4-6, 2015
June 3-5, 2015
September 2-4, 2015
December 2-4, 2015

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ PHONE CHANGE

_____ ☐ RN ☐ LPN ☐ APRN _____
Missouri License Number Social Security Number

→_____ _____
Signature *(This form must be signed)* Date

NAME AS CURRENTLY IN OUR SYSTEM

_____ _____
First Name (Printed) Last Name (Printed)

NEW NAME

_____
Last Name First Name Middle Name

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

(_____)_____ _____
Daytime Telephone Number E-mail Address

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ **I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.**

Return completed form to: Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or

Fax to 573-751-6745

If you wish to obtain a duplicate license you must return this form along with your current wallet-size license and a $15.00 check or money order payable to the Missouri Board of Nursing.

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